ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, its Medical Examinat must be notified at 72 hours after 21215-0036 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event. Maryland ltimore,

ZEZ

Completed

Be (

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15. Decedent's Education (Specify only highest grade completed)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

na

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

<u>Vivian</u> Boone-Niece

4 Donation 5 ☐ Other (Specify)

8th grade

Jim Stuart

20a. Method of Disposition

Physician /Medical Examiner

bu bu burial-transit the

or Attending Physician: The law requires that the death certificate be executed attending physician the signed by t page 2 should certificate has After this certification, properties death.

Division of Vital Records, P.O. Box 68760,

21. Signa re / Funeral Service Licensee 22. Name and Address of Facility March F/H West anald 23a. Par 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death mudiate Cause (Final Subarachnoid Henrorshage disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence) of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Cerebral Infact that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Year Dav 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2√2No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

RES-

Hospital

000

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

Homemaker

Give kind of work done during most of working life. DO NOT use retired)

Garrison Forest Vet 11/12/08

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

2703 North Rosdale Street, Baltimore, Md 216

Minnie Lock

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

House

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

2008

MD, 21215

Nov'03

Baltimore

Owings Mills, Md

DHMH 17 Rev 1/2001

State Registrar

within 24 hours after death To the Funeral Director:

the Hospital

filled in by

completely

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MOHIT

Mohit Speotra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIRDTRA

MD

MA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			for State Registrar	State of Maryland		tificate of Death			eg. No	008	35502
	Physici	an	1. Decedent's Name (First, Middle, La.					Date of Deat		Year	3. Time of Death
	/Medic		Robert	Maurice		White			02	2008	5:00a. M
	Examin	er	4a. Facility Name (If not institution, giver 4002 Garrison			4b. City, Town, or Location Baltimore			4c. Co.	unty of Death	
	Funeral Director		5. Social Security Number 214-40-6478		birthday) Yrs.	If Under 1 Year If Under Months Days Hours		Date of Birth (Month, Day,		Cour	place (State or Foreign htry)
land	Wo #		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	ation	-			1	0d. Inside City Limits
Mary	a-f sh	ctor	MD NA	Ва	altin	nore					1X Yes 2 □ No
th with the	23a or 28 list be no	Funeral Director	10e. Street and Number 4002 Garrison l	3 lv d		10f. Zip Code 21215	5	11	_	of What Cour	ntry?
5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It e Medical Extraulrer mast be notified at once.	þ	11. Marital Status 1 Never Married M Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates:		las Decedent of Hispanic C Yes, specify Cuban, Mexica Yes 21 No Specify		y Yes or No- an, etc.)		Race - Americ Black, White, ecify: B1	etc.
15-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation 1 de completed)	6a. Deced	ent's Usual Occupation ind of work done during mo O NOT use retired)	est of working	Ţ	16b. Kind o	of Business/In	dustry
2121 within	than	omp	Elementary/Secondary (0-12) 11th grade	College (1-4or 5+)		o nor use retired) f Trust Ass		er s	aco	Lumbe	r Company
nd in the	al Hyg i othe i went,	Be C	17. Father's Name (First, Middle, Last)				her's Name (F			,	
'ylaı	Ment narked natic e	인	Paul S. White				othy E				
Maryland 21215-0036 and 2 should be filed within 72 hours aft	of Health and Item 27 Is n other traun		19a. Informant's Name/Relationship (Dianne White-w	ife	4002	Address (Street and Num. Garrison E	Blvd,	Balti	more	, Md	21215
Baltimore,	ment of H ant: If Ite lury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2)			ition (Name of atory or other place) orial Park	11/7/			ion - City or To llawn ,	
Ball Permit	Depart Import any in		21. Signature of Funeral Service Licer	isee	Ma	Name and Address of Faci F/H We	st.				
	,		23a. Part 1. Enter the disease, or com	plications that aused the death. [OO Wabash .				, Md	21215 Approximate
	ysician Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. cardin	nyo	nathy					Interval Between Onset and Death
	xaminer			Due to (or as a consequent	CONT ?	nary he	art	Diffe	225	2	2002
De De	ii.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequent	ce of):	0					7000
xecut	and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequent	ce of):						2002
68760, criticate be executed	ng physician and as the burial-transit			d. Hypen	ter	s, on					50 year
c 68 ertifica		Medi	IF FEMALE:			-					
P.O. Box	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)			23d.	Date of deliven. Month	ery Day Year
rds, P.	been signed by the should be detached	ð	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						id tobacco use contribute to the cause of death? ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown		
Division of Vital Records,	te has bee age 2 shou	Completed	-					24a. Was ar autops perform	y ned?	prior to co death?	psy findings available mpletion of cause of
/ita	ertifica ector, p	Be C	25. Was case referred to medical examiner?				ce of Death (C	1 □ Yes 2 Check only on	/	I LL TES	2/2/140
of Physi	rthis o		1 ☐ Yes 2 ☐ No 27. Manner of Veath	Hospital: 1 Inpatient 2 ☐ ER. 28a. Date of Injury 28	Outpatient b. Time of			5 Reside		Other (Specif	y)
On	ith. : Aftel e fune	tion	1 Natural 5 Pending investigation	(Month, Day, Year)	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐		i. Describe no	w injury oc	currea	
Division Atten	s after dea Il Director Id in by the	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	_, = 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					il Route Number,	
e Hospit	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ledical C	29a. Certifier (Check only one)	nysician: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, date a estigation, in my opinion, de	and place, and eath occurred	d due to the ca	ause(s) and ate and pla	d manner as s ace, and due to	stated. the cause(s)
To th	within To the comp	Me	29b. Signature and title of certifier	11/200	ne	29c. License number	100	29	9d. Date si	igned (Month,	Day, Year)
	9		30. Name and address of person who	completed cause of death (Item 23	(Type, P	rint) Ralt	mor	e	ma	121	2 2 8
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 7 2008	32. Registrar's Signature	Page 1						
DHMH	17 Rev 1/2	001	THE U & LUVU	basines in the	A CONTRACTOR OF THE PARTY OF TH						

Physician /Medical Examiner physician and s the burial-trans Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural" any injury or other traumatic events.

been signed by the attending should be detached for use as To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	•	iserre			yeur	
ysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of	al death 3 🗆 Ectopi	c pregnancy (specify)		23d. Date of do	elivery Day Year	
pieted by Pr	Part II. Other significant conditions of	contributing to death but not res		•	1 ☐ Yes	2 ∰No 3 □ F	to the cause of death? Probably 4 🗆 Unknown	
Compi					24a. Was an autopsy performed 1 □ Yes 2 🗗	prior to	utopsy findings available completion of cause of s 2 No	
e n	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
ation: I	27. Manns of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At nome, farm, street, factory, office 28f. Location				n (Street and Number or Rural Route Number, Town, State)		
edicai		nysician: To the best of my kno niner: On the basis of examina and manner stated.						
Ž	29b. Signature and title of certifier	Saly w)	29c. License number		Date signed (Mor	th, Day, Year)	

State Registrar

14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smennyo

21202

Beltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** illiams 1ae e o /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner** Dice 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign (In yrs. last birthday) **Funeral** 1 M 2 AF Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amount in Jury or other traumatic event, it a Medical Examiner mant be redified at once. 23a or 28a-f show 1XYes 2 No Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 □Yes 2 Ho If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>ک</u> Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surnal 17. Father's Name (First, Middle, Last) ۵ 19a. Informant's Name/Relationship (Type. or Town, State, Zip Code 1239 19b. Mailing Address (Street and Number or Rural Route Number, Sity Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) re of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of civil shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached t 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by diseuse 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of confifie 2520 eddress of person who completed cause of death (Item 23a) (Type, Print) N. Clorles St. Bolto. M4 21 70 X

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Year)

07

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death No Wonth 2 2008ar Рм George Everett Wagner 3:15 4a. Facility Name (If not institution, give street and number) 2360 Braddock Rd. 4b. City, Town, or Location of Death Mt. Airy 4c. County of Death Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Sex M 2□ F 8. Date of Birth 3 (1991) (1991) Birthplace (State or Foreign Country) Months Days Hours Min 220-30-9072 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Carroll 1 ☐ Yes 2 No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2360 Braddock Rd. 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 □ Yes 24 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Southern States Farm Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles William Wagner Esther Mae Condon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris W. Wagner (Wife) 2360 Braddock Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place)
S. Carroll Crematory 11/3/2008 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euro 22. Name and Address of Facility 1212 W. Old Liberty Rd Winfield, MD 21784 Burrier-Queen Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD disease or condition resulting in death) 25 vears Due to (or as a consequence of):

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran. Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director MD

Funeral

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Be Completed

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

death with the Marylan

Pages 1 and 2 should be filed within 72 hours after

of Health and Ments if item 27 is marked

Maryland 21215-0036

e069 Baltimore,

agne

by Physician/Medical Examiner Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury	Due to (or as a consequence of):	
that initiated events resulting in death) Last	Due to (or as a consequence of): d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1☐XYes 2☐ No 3☐ Probably 4☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2₺₽No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 Yes № No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Horr	ne FResidence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of lnjury 28c. Injury at Work? 1 Yes 2 No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	/sician: To the best of my knowledge, death occurred at the time, date and place, a finer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated. If and the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	MD 29c. License number D004609	29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hope McIntyre, MD 1502 S. Main St. Mt. Airy, MD 21771

32. Registrar's Signature

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

1117 11th Street

MICHAEL

5. Social Security Number

336-38-0781

TALBOT

6. Sex

1 ∏ M 2 □ F

4a. Facility Name (If not institution, give street and number)

WYATT

7. Age (In yrs. last birthday)

Yrs.

63

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV • 11, 1944 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Examiner must be notified at 1√Xes 2□No Directo Prince George's Laurel MD 28a-f 109. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1117 11th Street 20707-3601 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 XX Married "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 X o Specify: Specify: White ģ -19653 Widowed 4 Divorced Completed Injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 12 marked other than College (1-4or 5+) Salesman Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I Betsy Eaglesham Arthur McIlroy Wyatt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trauonce. Denise Cole Wyatt 1117 11th Street Laurel, Maryland 20707-3601 spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛮 🖔 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 11/7/2008 Odenton, Maryland 21. Signature of Funeral Service Licensee Bonard Address of Facility al Home, P.A. /M00770 313 Talbott Avenue 20707-4389 Laurel, Maryland 23a. Part 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Xsanque /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 1☐ res 2 ☐ No Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 28b. Time of 27. Manner of Death After Injury within 24 hours arier .c...
To the Funeral Director: Aff 1 Natural 5 Pending arred 1 ☐ Yes 2 ☐ No investigation Novembers 2 Accident ead 28e. Place of Injury - it home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be City or Town, State) determined Dojue street, Louise Marc, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVATOR 00/ 31. Date filed (Month, Day, Year) State 2008 NOV 0 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

overleer 5

3. Time of Death

9. Birthplace (State or Foreign

New York

Peres

Prince George's

4c. County of Death

1156 M

AMEND TTEM#2 per PHYS C885 11 1 18 08 WS State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAPEA14 RNOLD 1RUNDOL Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 📉 🔭 Year) Months Days Hours Min. 080.05.8147 Director JULY 2, 1910 RHODE ISLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 □Yes ŽŽNo **Funeral Director** MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 W. MCKINSEY RD. 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【\No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Completed by Specify Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LIBRARY CLERK OHIO GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. LARKIN DAUGHTER 609 DELAWARE AVE., GLEN BURNIE, MD 21060 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot GLEN HAVEN CEMETERY NOV. 7, 2008 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22 Name and Address of Facility FINK FUNERAL HUME, P.A. K. SREGORY 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 FINK M01148 23a. Part 1 Enter the iseas, or ormalications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Ist on to re cause on each line.

Immediate C ise (Final disease or condition resulting in death)

a. TASTATIC PANCEPONT CANCEPONT C Approximate Interval Between Opset and Death **Physician** MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by STEOARTHRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate l 1 □ Yes 1 ☐ Yes 2 ☐ No 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 1 Yes 2 ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 ☐ Natural
2 ☐ Accident 28b. Time of 28d. Describe how injury occurred s after dea. al Director; After 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHA 31. Date filed (Month, Day, Year State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Israel Warshaw 9:30 PM November 5, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1X M 2 □ F 578-24-4528 82 Director 11/30/1925 NY Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show 10a State 10b. County Director MD 1 Yes 2 No Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 3703 Stewart Dr. ral", or items 23a 20815-Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumetic event, Ite Medical Examinations. Black, White, etc. 1 Yes 2 I I Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ģ 3 Widowed 4 □ Divorced 1944-1946 Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Warshaw ۵ Dora Solomon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Bronstein/Sister 9M Southway Greenbelt, MD 20770-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2008 Beltsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Services 101533 933 Gist Ave. Silver Spring, Maryland 20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** 4 cute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OSEFSIS Sequentially list conditions, any leading to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed hrombocy topenia Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 MNo 24a. Was an autopsy performed? funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1¥ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartific 29c. License number 0 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) Glen rd. Silver Spring, MD Anglin 31. Date filed (Month, Day, istrar's Signature Year) State 2008 NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:027 M **Physician** 2008 Young /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Saltimore Chris Hospice 8. Date of Birth (Month, Day, Year) 10-28-1933 Birthplace (State or Foreign Country) 6. Sex If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 🗓 213-30-2354 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov ral", or items 23a or 28a-f shov Examiner must be notified at 1 Tyes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Penti 1542 21239 "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FIN Baltimore C 2415 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ring Gold Mosby 9 ouisa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Ywng MDSBL .15q M. 94 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 22. Name and Address of Facility Cours C. Oceans Funeral Services

4905 your and Address of Facility Course C. Oceans Funeral Services 1 ☐ Burial 2 ☐ Peremation 3 ☐ Removal from State Greenmount Crematory 11.10.2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaughn C. Rheene 4905 Pork Pd Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Caso Physician Montas resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, 0/28/33 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy 2 100 1 ☐ Yes 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO38 LL 20 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 58303 November 5 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST TONDER MD 21204 i. HAMVES WY AARUN 32. Registrar's Signature State 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Of Maryland / D State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of I		2. Date of Deat	eg. No. 200 h	3. Time of Death	
Physi /Med	dical	Antwon Asael Hernandez As 4a. Facility Name (If not institution, give street and number)	scencio	Location of Death	oct.1	8 , 2008 Yea 4c. County of De		
Exam	О	Shady Grove Adventist	Rocky		O. Duta of Dinth	Montg	omery	
Funera Directo		454.00	rs. Months Pays	Hours Min.	8. Date of Birth Menth Day, 6 / 0 2 /	2008 M	irthplace (State or Foreign Country) aryland	
Maryland I-f show	tor	10a. State 10b. County 10c. City, Town	or Location hersburg				10d. Inside City Limits 1 □Yes 2X No	
th with the 23a or 286	al Dire	10e. Street and Number 119 Rowlings Road	10f. Zip Code 20877	7	1	0g. Citizen of What 0	Country?	
be filed within 72 hours after death with the Maryland rital Hygiene. I have seen than "natural", or items 23a or 28a-f show event, it a Madical Experiment must be inclified at	by Funeral Director	11. Marital Status 1 ★ Never Married 2 ★ Married 3 ★ Widowed 4 ➡ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ★ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1X Yes 2 □ No			Black, Wh	nerican Indian, hite, etc. White	
d Z I Z I 3-0030 filed within 72 hours aft Hygiene. other than "natural", or ent, II. Medical Extent	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation		16b. Kind of Busines	ss/Industry	
yidild A ould be filed v Mental Hygis arked other attc event, u	a)	17. Father's Name (First, Middle, Last) Miguel Noel Hernandez	none	18. Mother's Name			ncio	
and 2 should be eaith and Menta n 27 is marked oner traumatic ev			Mailing Address (Street		Gaithe	rsburg,M	d 20877	
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Gener	Disposition (Name of y, crematory or other place ral Cemete	ery 10/2	1/2008	El Sal		
permi Depar Impor	once	21. Signatur of uneral Service Licensee	9241 colu	紹介MALDI mbia Bl	FUNERA vd.Sil	AL SERVI ver Spri	CE,P.A. ng,Md20910	
Physicial /Medica Examine	al er	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio Pulmo Due to (or as a consequence of Trachioesoph	onary Arre nageal Fis	st	or respiratory arr	est,	Approximate Interval Between Onset and Death	
rtificate be executed ng physician and as the burial-transit	Lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the cause	Dysplasia					
ding Physician: The law requires that the death certified. After this certificate has been signed by the attending pruneral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)				23d. Date of delivery Month Day Year	
w requires that been signed should be del	₽ S	Part II. Other significant conditions contributing to death but not resulting in	tributing to death but not resulting in the underlying cause given in Part I.				to the cause of death? Probably 4 Unknown	
ician: The law rectificate has be	e Completed	25. Was case referred to medical		26. Place of Deatl		sy prior : med? death 2 ☐ No 1 ☐ Y	autopsy findings available to completion of cause of ?	
I or Attending Physician: after death. Director: After this certific d in by the funeral director.	Certification: To Be	2 Accident investigation	ime of a 28c. Injury Worl	er: 4 \(\sum \) Nursing Ho y at Yes 2 \(\sum \) No</td <td>me 5 ☐ Reside 28d. Describe ho</td> <td>ence 6 ☐ Other (S ow injury occurred</td> <td></td>	me 5 ☐ Reside 28d. Describe ho	ence 6 ☐ Other (S ow injury occurred		
pital or Attenurs after deat ors after deat eral Director;	Certif	4 Homicide determined building, etc. (Specify)			City or Tow	n, State)	Rural Route Number,	
To the Hospital or Within 24 hours after To the Funeral Director Completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	, death occurred at the tild/or investigation, in my o	pinion, death occur	red at the time, o	cause(s) and manner date and place, and d 29d. Date signed (Mo	due to the cause(s)	
¥ ¥ ₽ 8		1 A Milelle	5	2604	,	Oct 18	2, 2008	
		30. Nan's Traddress of Marson win completed Mus of doily (Nem 22 M)	edical Cen	ter Dr.	Rockvi	lle,Md		
Regi	State strar	OCT 2 4 2008	perti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** BABY 20:36 PM BOY SANTE 2008 10 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ADVENTIST KOCKVILLE, MARYLAND GROVE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 10 M 2 F 10 30 2008 MARYLAND NONE Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State r than "neturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Kres 2 □ No MONTGOMERY ROCKVILLE, MARYLAND MD Director 10f. Zip Code 10g. Citizen of What Country? USA 20855 HAVENSIDE ERRACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. BLACK Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) INFANT INFANT permit. Pages 1 and 2 should be filed with Depertment of Heelth and Mental Hygien, important: if Item 27 is marked other the eny injury or other treumatic event, Item 2006. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BOATENG MELDOMI KINGSLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HAVENSIDE TERRACE, KOCKVILLE, MD20855 BOATENG, FATHER 7728 KINGSLEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State HALL RIVER, NC 12/01/2008 CYCLE STERI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MEDICAL CENTER DRIVE, ROCKVILLE 9901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PREMATURIH EXTREME **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit ettending physicien end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Da Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 4□Pregnant at time of death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the compistely filled in by the funeral director, page 2 should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 TYes 2X 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: Certification: To 1 ☐ Yes 2 🕱 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 | Homicide To the Hospital 10 Conflying Physician: To the best of my knowledge death occurred at the time. Tale and file in the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number certifie

State Registrar ANDERS

31. Date filed (Mont)

DHMH 17 Rev 1/2001

30. Name and address it her on who completed cause of death (Item 23a) (Type, Print)

32. Pisgistrar's Signature

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AKGAR, MD.

D0058033

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

10/30/2008

Physic /Med Exami

Funeral Director

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	FOI	ertificate of Death	Reg. N	2000	35512					
ion	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	av Year	3. Time of Death					
ian cal	Patrice Doherty Blankenship			22 2008	6:15 A M					
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death						
	16429 Equestrian Lane	Derwood Jerwood Jerwood Jerwood Jerwood Jerwood		Montgomer						
	5. Social Security Number 6. Sex 1 M 2 1 F 7. Age (In yrs. last birthdom) 1 M 2 1 F 77 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Yea Sept. 23, 1	r) 9. Birthi Coul MA	place (State or Foreign ntry)					
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits					
ctor	MD Montgomery	Derwood			1 □Yes 2 No					
Be Completed by Funeral Director	10e. Street and Number 16429 Equestrian Lane	10f. Zip Code 20855	-	10g. Citizen of What Country? United States						
nera	11. Marital Status 12. Was Decedent Ever in U.S. 1	 I3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	pecify Yes or No-	14. Race - Ameri						
by Fu	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 Mo If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:	to ricall, etc.)	Black, White, Specify: Wh						
eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired)	rking 16b.	Kind of Business/Ir	dustry					
Ę	Elementary/Secondary (0-12) College (1-4or 5+)	Realtor		Real Esta	ite					
ပ္သ	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide							
To Be	Esmonde Doherty	Mildre	ed Mutrie							
۲		iailing Address <i>(Street and Number or R</i> 29 Equestrian Lane			o Code)					
-	-	sposition (Name of crematory or other place)		Location - City or T	own, State					
	4 Donation 5 Other (Specify) Holyhoo	d Cemetery 2	ber 28 008 Bro	ookline,	MA					
	21. Signature of Funeral Service Ucensee I RACY + Stute	22. Name and Address of Facility DeVol Funeral Home	e, 10 East	Deer Park	c Drive					
	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	20077	Approximate Interval Between					
	Immediate Cause (Final disease or condition Lymphoma									
	resulting in death) a. Due to (or as a consequence of):		3 Years_							
١.	Sequentially list conditions b.									
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or highly that initiated events C.									
хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
Medical Examiner	d									
Med	IE EEMALE:									
an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delive	very Day Year					
Completed by Physician/N	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	5 ☐ Other (specify)		World	Day 1 dai					
≥ P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?					
ed k			1 ☐ Yes	2XNo 3 Pro	bably 4 Unknown					
plet			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of					
ĕ			performed 1 Yes 2 🗖	? death? No 1 ☐ Yes						
Be (25. Was case referred to medical examiner?		ath (Check only one)							
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ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 1 Natural 5 □ Pending (Month, Day Year)		28d. Describe how in	jury occurred						
icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm		28f. Location (Street	and Number or Ru	ral Route Number					
Certif	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)						
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.									
M	29b. Signature and title of certifier Fraule Werthurl	29c. License number	85 Oct	Date signed (Month	, Day, Year) 2 2008					
	30. Name and address of person who completed cause of death (Item 23a) (Ty Frauke Westphal, M.D., 1201 Seven I		tomas MD	20854	ŧ					
ate	31. Date filed (Month, Day, Year)	Joeks Ruau 1/202, P	ocomac, PID	20034						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#5per INF, 10-28-08, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 8:55 PM 20 2008 Maria Carla Barzotti October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12610 High Meadow Road North Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 88 Director 29,1920 Ital_v Mar. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No MD Montgomery North Potomac Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12610 High Meadow Road 20878 Italy within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No White þ Specify 3 X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 lent of Health and Mental Hygiene.

1: If item 27 is marked other than "n y or other traumatic event. The Menti: Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ercole Barzotti Margherita Marisaldi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Anna Maria Cantarella/Daughter 12610 High Meadow Road, North Potomac, MD 20878 Baltimore, Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other p Gate of Heaven Cemetery Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 24 2008 permit. Page Department o Important: If any Injury or 4 □ Donation 5 🖔 Other (Specify) Entombment Silver Spring, MD 22. Name and Address of Facilit 21. Signature of Funeral Service DeVol Funeral Home, 10 East Gaithersburg, Md RACY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Dementia 5 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) physician at s the burial-t Box 68760 Physician/Medical as attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🗓 No Month 4☐Pregnant at time of death P.O. signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2

No 3

Probably 4

Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page certificate 1 ☐ Yes 2 No Division or Vital 1□ Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA After this c ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie 29b. Sigr 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

31. Date filed (Month, Day, Year)

OCT 24 2008



D21531

October 21, 2008

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			1- State o		epartment of H C <i>ertificate of L</i>			ne 2008	35514
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
4	Physicia		NETTIE ELIZABETH BO	WERS				Day Ye <i>a</i> r 28 2008	9:11 P M
100	/Medic Examin	-	4a. Facility Name (If not institution, give street and nur		4b. City, Town, or	Location of Death		4c. County of Death	7.11
	X		21716 BLACK ROCK ROAD		HA	AGERSTOWN		WASHIN	IGTON
	Funeral	- 1	Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthr	place (State or Foreign
Ш	Director		216-22-2046 1□M 2\\ \text{\$\text{\$\text{\$\text{\$T\$}}\$}\$}\]	88 ^Y	rs. World's Days	TIOUIS WIII.	APRIL 24,		RYLAND
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			1	10d. Inside City Limits
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	the M 28a-f lotifie	Director	MARYLAND WASHINGTON 10e. Street and Number		10f. Zip Code	HAGERSTO		Citizen of What Cour	ntry?
	a or				101. Zip 00de	017/0	139.		
	eath Is 23 Musi	era	21716 BLACK ROCK ROAD 11. Marital Status 12. Was Dec.	edent Ever in U.S.	13. Was Decedent of H	21742 ispanic Origin? (Sp	ecify Yes or No-	U.S.	
	fter d r iten iner	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	rces? 2 X No	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Girl Year or D	/e ates:	1 □ Yes 2 🙀 No	Specify:		Specify:	WHITE
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Maryland	l 2 sh n and is m		19a. Informant's Name/Relationship (Type. Print) JOSEPH A. BOWERS SR./SON	I .	Mailing Address (Street:				·
	les 1 and 2 should be of Health and Mental of Health and Mental filem 27 is marked or other traumatic even		20a. Method of Disposition		.716 BLACK F			. Location - City or To	
Baltimore,	Pages nent of I int; If Ite		1 M Burial 2 ☐ Cremation 3 ☐ Removal from	State cemetery	, crematory or other plac	ce)		•	
≣	it. Partmen	23	4 □ Denation 5 □ Other (Specify) 21. Sign sture of Finer I Service Lice see	BEAVER	CREEK CEM.	: 10/:	31/2008 F	IAGERSTOWN	, MARYLAND
Ba	permit. Page Department of Important; If any injury or once.		Par Par	ul M. Dean	22. Name and Addres				HOME ryland 21713
			23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on	aused the death. Do no					Approximate
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9	ertific ing p e as t	Mec	IF FEMALE:		190000			1	
. Box	leath certific attending p I for use as	ian/	23b. Was decedent pregnant 1 □ Live I	come pf pregnancy pirth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy	/		23d. Date of deliver Month	ery Day Ye <i>a</i> r
_ _	the a	Physician/Me	1 ☐ Yes 2 【 Dec 4 ☐ Pregi 9 ☐ Unknown 9 ☐ Unkn	nant at time of death own	5 ☐ Other (specify) _				
<u>Р</u>	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	P	Part II. Other significant conditions contributing to d	eath but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
Vital Records,	signe d be	Completed by	Duketes		, ,		1 ☐ Yes	2 7 No 3 □ Prol	bably 4 Unknown
Ö	v requ	etec	Dudal releas				24a. Was an	24h Wara auto	anay findings available
He	The law cate has I page 2 s	mpl	Juster Wells				autopsy performed	prior to co	opsy findings available ompletion of cause of
<u></u>	iclan: Th certificate rector, pag		Of Was and referred to realize				1 Yes 2 ✓		2☐ No
	ysician: vis certifica director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2 ☐ ER/Out	nationt 2000 Oth	05:	th (Check only one)	o □ou	7. 1
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Division or	Atter r dea ector by the	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of injury - At home, far	m, street, factory, office			t and Number or Run	al Route Number,
	al or s after il Dire	Certification:	4 ☐ Homicide determined build	ing, etc. (Specify)		;	City or Town, S	nate)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the (Check only 2 Medical Examiner: On the base)	e best of my knowledge,	death occurred at the til	me, date and place	, and due to the caus	se(s) and manner as s	stated.
	the H iin 24 the Fi	Medical		ner stated.					
	Vith To 1	Σ	29b. Signature and title of certifier		29c. Licens			Date signed (Month,	
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2	4-3		30. Name and address of person who completed cause VINC. PIX A. CANTONE		Type, Print)	- R1.10	Cm'+th o	hara M	1/08 1783
ال	4-3	to		Restrar's Signature	1 UCTTESC	11 000	OMILIA 2	rourg "	2 21 18 2
	Sta Registr		OCT 2 9 2008	Man 15	Bosselle			~	

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amend #14 Per FH G885 11/13/08 JH.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Weslev Dewitt Bush 18, 2008 9:25 p October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days XXM 2□F 39 Director 215-80-3236 27, 1969 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Charles Bryantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13790 Edelen Drive 20617 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🔀 Married **Black** Maryland 21215-0036 1 ☐ Yes 2√TtNo Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Construction Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Alice Kay Bush ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Medley-Bush/Spouse 13790 Edelen Drive, Bryantown, Maryland 20617 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 10/25/2008 Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furteral Service Licensee Brinsfield-Echols Funeral Home, P.A. 31095 Three Notch Road, Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC **Physician** ARRES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Dav 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 YNo page 1 □Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending nours after death.

neral Director: All 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cishen win 044885 Ewo an 10-22-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suitland IVIX 5100 Auth War 31. Date filed (Month, Day, Year) 200\$ Registrar

		For State Registrar	State of Maryla	nd / Depa		Health and	Mental Hyg	-	35516
Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last) Duane Ronald 4a. Facility Name (If not institution, give s Charlotte Hall Vo. 5. Social Security Number 6. Sex	eterans Home	va lant hirthdau	Charle	or Location of Deat Otte Hall If Under 24 Hrs	L	29, 2008 4c. County of Death St. Mary	
Funeral Director			IM 2□F 86	s. last birthday) Yrs.	Months Days	Hours Min.		27,1922 I	intry) Llinois
death with the Maryland ims 23a or 28a-f show r.must be rotified at	Director	10a. State 10b. County Maryland Charles 10e. Street and Number		City, Town or Lo				IO Citizen of What On	10d. Inside City Limits 1 □ Yes 2 No
be filed within 72 hours after death with the Marylan tatal Hygiene. tatal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Mudical Examinar must be notified at	by Funeral Dir	12700 Shore Place	12. Was Decedent Ever in Armed Forces? 1X_Yes 2 □ No If Yes, Give Ye ar or Dates:	ļ	2066	Hispanic Origin? (S an, Mexican, Puer	Specify Ye's or Noto Rican, etc.)	USA 14. Race - Amer Black, White Specify: Wh:	ican Indian, , etc.
e filed within 72 hours after a filed within 72 hours after a filed within 47 hours after other than "natural", or ite went, the Mudical Examining	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retire Retail Sa	during most of wo		16b. Kind of Business/li	ndustry
2 should be file and Mental Hy is marked oth aumatic event	To Be	17. Father's Name (First, Middle, Last) Ernest Earl Bowma		405 44-35		Effie	Maud	,	
1 and 2 Health a		19a. Informant's Name/Relationship (Ty/ Richard J. Castal 20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ R	di/Friend/PO 20b emoval from State	A 1270 Place of Dispo	O Shore sition (Name of matory or other pla	Place, Na	anjemoy,	r, City or Town, State, Z MD 20662 20c Location - City or Third Con.	· · · · · · · · · · · · · · · · · · ·
permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	4 400017	22	Nationa Nationa Name and Addre Brinsfie	ss of Facility	mber 4,20 s Funeral	008 Virgin l Home, P.A lotte Hall,	_
Physician /Medical Examiner	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Congeshue Heart Jallure Due to (or as a consequence of):							
eath certifical attending phy for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	tal death 3	☐ Ectopic pregnand	cy		23d. Date of deli- Month	very Day Year
quires tha	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute to es 2 □ No 3 ☑ Pro	the cause of death? bably 4 \sum Unknown
ician: The law requires t sertificate has been signe ector, page 2 should be c	e Completed	25. Was case referred to medical				26 Place of Da	24a. Was a autops perform 1 Yes ath (Check only on	red? prior to c death? 2 ☑No 1 ☐ Yes	opsy findings available ompletion of cause of 2 1400
or Attending Physi fiter death. Director: After this on in by the funeral direction	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Homicide	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At building, etc. (Spe	28b. Time of Injury	f 28c. Inju Wor M 1	ner: 4 Nursing F	fome 5 ☐ Reside	ence 6 Other (Spec ow injury occurred	
To the Hospital within 24 hours a To the Funeral I completely filled	Medical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	e, and due to the curred at the time, d	cause(s) and manner as late and place, and due	stated. to the cause(s)				
To the within 2 To the comple	Me	29b. Signature and title of certifier	and manner stated.	am 92-1 /T	29c. Licens 26.7		2	29d. Date signed (Month	, Day, Year)
Sta		30. Name and address of person who co FRONCISCA BRUNEY, 31. Date filed (Month, Day, Year)	29449 C	harlott	e Hall R	d. Charlo	otte Hall	, MD 20622	
Registr HMH 17 Rev 1/20	-	OC∓ 8 1 20	08 Breve	N A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 008 1 - For State Registrar Certificate of Death

2. Date of Death Month 10/21/2008

35517

3. Time of Death

6:15A M

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Henry Bauer

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

miner	4a. Facility Name (If not institution, give street and number) Vindabona Nursing Home						4b. City, Town, or Location of Death Braddock Hgts 4c. County of Death Frederic						
201		cial Security Number			(In yrs. last i	birthday)	If Under 1 Year		Hrs. 8. Da	te of Birth			hplace (State or Foreig
ral tor	21	6-38-27	47 ×	TH OFF	7	Yrs.	Months Days	Hours N	^{vlin.} 4 ^(M)	17771	941		$\mathbf{D}^{try)}$
		al Residence of Dece											
once. To Be Completed by Funeral Director	10a.		County		10c. City, To			NE/P					10d. Inside City Limits
55	MD Frederick Middletown						1 ☐ Yes 24☐XNo						
Funeral Director	10e.	7311 Po	plar L	ane			10f. Zip Code 2	1769		10	g. Citizen of $\mathbb{US} A$		untry?
era	11.1	Marital Status		12. Was Decedent E	ver in U.S.	13. W	as Decedent of	Hispanic Origin ban, Mexican, P	? (Specify Y	es or No-	14. Ra	ce - Ame	rican Indian,
		□ Never Married 2	2000 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	0				uèrto Rićan,	etc.)		ck, White	
Completed by		B ☐ Widowed 4 ☐ E	Divorced	If Yes, Give Year or Dates:		11	1 □ Yes 2፟ ⊠ No <i>Specify:</i>				Speci	⅓: Wh	ite
etec			Decedent's Edu ally highest grad		16	6a. Decede (Give ki	nt's Usual Occu ind of work done	nt's Usual Occupation Ind of work done during most of working NOT use retired)			6b. Kind of E	Business/	Industry
du	E	ementary/Secondary	(0-12)	College (1-4or 5+	-)		tmaste:				nosta	າ1 ຊ	ervice
ပ္သ	17.	Father's Name (First,	Middle, Last)			pos	Linas Ce.	18. Mother's	Name (First				CIVICO
To Be	1		Elmer	Bauer					othea				
-		. Informant's Name/F	Relationship (T)	rpe. Print)	1	9b. Mailing	Address (Stree	t and Number o	r Rural Rout	e Number,	City or Towr	, State, 2	Zip Code)
	J	oAnne Ba	uer (V	Vife)		7311	Popla	r Lane	, Mic	ldlet	own,	MD	21769
	20a.	Method of Disposition		Damas State	20b. Place	of Disposi	tion (Name of	cek	Date	2	0c. Location	- City or	Town, State
		4 □ Donation 5 □			Gard	en o	f Fait	h 10	/24/2	2008E	Baltin	nore	, MD
	21.	algnature of Funeral	Service Lidens	ee 06		²² D	Name and Addr	Bes of Facility	mpsor	Fur	neral	Hom	ne
_	_	1 was	IM	ergo		P	OB 18,	Middl	etowr	, MI	2176		
			sease, or complure. List only o	lications hat caused t ne cause on each line	the death. D	o not enter	the mode of dy	ing, such as car	rdiac or resp	iratory arre	st,		Approximate Interval Between Onset and Death
cian lical	dise	Immediate Cause (Final disease or condition resulting in death) a. GLOBUSTONA MULTIFORME										→ THS	
	103	Due to (or as a consequence of):											
7	Sec	uentially list condition	ns,	bb. Due to (or as a	consequenc	e of):							
Ĕ	cau	uentially list condition by, leading to immedi se. Enter Underlying se (Disease or injury		500 10 (01 03 0	consequenc	01).							
Examiner	resi	initiated events ilting in death) Last	ce of):										
Physician/Medical	-	51115	150										
an/I		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Ye											
Sici		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ins?	4☐Pregnant at t 9☐Unknown			Other (specify)	-,			· ·	onth	Day Year
Phy	Port		l conditions co		t t	- i 4b		in Don't		D. Didas		A-24 - 4 - 4 -	
þ	Fait	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of d											
Completed	-								- -	1	5 22110		obably 4 ☐Unknowi
ďω	-								2	4a. Was an autopsy perform	/	prior to	utopsy findings available completion of cause of
	0.5	Management								☐ Yes 2	□ No	death? 1 ☐ Yes	2 □ No
) Be		Was case referred to examiner? 1 ☐ Yes 2 ☐ 🗝 6	-	Hospital:		0	a 🗆	26. Place of her:					
5 :	27.	Manner of Death		1 ☐ Inpatien 28a. Date of Injury	y 28t	Outpatient b. Time of	3 DOA 28c. Inju	4 🗀 Nursir			nce 6 Ot		cify)
atio		1 ☑ Natural 5 [2 ☐ Accident	Pending investigation	(Month, Day	Year)	Injury		ork?]Yes 2∐No					
Certification:		3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of injur building, etc.	ry - At home,	farm, stree	et, factory, office		28f. Lc	cation (Str	eet and Num	ber or Ru	ural Route Number,
Cer		· Briomoido		building, etc.	. (Specify)					ty or Town,	, State)		
	29a	. Certifier 1.	Certifying Phy	sician: To the best of iner: On the basis of	f my knowled	dge, death	occurred at the	ime, date and p	place, and du	ie to the ca	use(s) and n	nanner as	s stated.
Medical		one)		and manner stat	ed.	ana/01 11140			occurred at	rie unie, da	ate and place	, and due	e to the cause(s)
2	29b	29b. Signature and title of certifier					29c. Licer	se number		29	d. Date sign	ed (Mont	h, Day, Year)
		7	1	M no			Ī	132171			10	23/0	>8
	30.	Name and address o	of person who co	ompleted cause of de Po P 32. Registrat	ath (Item 23a	a) (Type, P	rint)			0.00	7		
ate	31.	Date filed (Month, Da	av. Year)	32. Registral	r's Signature	28 (MIKER	SUILLE	MO	2175	5		
rar		n	CT 2 3	2008	/	4 A	soule						
2001			0 1 2 0	- Just		-7							

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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permit. F Departm Importar any Injui		21. Signature of Funeral Service Lice	agward	Dôn'a1 4400	d V. Borgward Powder Mill R	t Funeral H oad Beltsv	Home, PA ille, Mai	cyland 20705	
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on each line.	ath. Do not enter the r	mode of dying, such as cardia	1/2111		Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed x 3 X V V V V V V V V V V V V V V V V V V		disease or condition resulting in death)		equence of):		archin		-	
	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consc	equence of).	nal Fa	elurq			
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 UNO 9 □ Unknowrf	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 Ectop	B ☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown							
: The law re cate has be page 2 sho						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 100	
ctor,	Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		- T-	
hysic his c I dire		1 Yes V No	Hospital: Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
ath. r: After t	ation:	27. Manner of Dath 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) on	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
al or Atte s after de il Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
n 24 hour n 24 hour ne Funera	Medical (29a. Certifier 1 CertifyIng P (Check only one) 1 Medical Exa	Physician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death occur nation and/or investiga	red at the time, date and plac tion, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)	
To T	Me	29b. Signature and title of certifier			29c. License number MSD 53 7/8	es l	Date signed (Mon	1	
1 -	Ì	30. Name and address of person who						<i>t</i>	
		THOMAS M. HAUS	SON M.S. 8/12	8 GOOD LUC	cRUAD LAW	JHARI MD.	20 70 6		
Sta	te	31. Date filed (Month, Day, Year)	Registrar's Sig						
Registr	ar	OCT 24 200	18 Boyce L	Apriles.					
MH 17 Rev 1/2	001			-					
				ORIGIN	AL				

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

4c. County of Death

Howard

Birthplace (State or Foreign Country)

10d. Inside City Limits

Virginia

8. Date of Birth (Month, Day, Year) Apr. 17, 1917

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

6. Sex

1 □ M 2 X F

5. Social Security Number

577-09-6408

10a. State

Usual Residence of Decedent

EllicottCity Health and Rehab Center Ellicott City

7. Age (In yrs. last birthday)

10c. City, Town or Location

Funeral Director

the Maryland Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 2 should be filed within 72 hours after death with 1 and Mental Hygiene. Is marked other than "natural", or Items 23a or ? permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is in any Injury or other traum once.

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

requires that the death certificate be executed the burial-tran attending physician use as ed by the a To the Hospital or Attending Physician: ours after death.

neral Director: After this
filled in by the funeral di within 24 hours a

To the Funeral C

completely filled

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 2 No Ellicott City Maryland Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 United States 3020 North Ridge Road,#W306 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Maryland State 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Elizabeth Price Hilary Gienger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12025 Sand Hill Manor Drive Marriottsville, Md.21104 Susie Reising -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/24/2008 Union Cemetery Burtonsville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease months disease or condition resulting in death) Due to (or as a consequence of) Hypertension vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteoarthritis; Hypothyroidism 1 ☐ Yes 2 【No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy performed? Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie B D30469 October 20, 2008

DHMH 17 Rev 1/2001

State

Registrar

Nandakumar Vellanki, M.D. 8850 Columbia 100 Parkway, #308 Columbia, Maryland 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

31. Date filed (Month, Day, Year)

OCT 24 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Francisco Luciano Dela Rosa October 2008 11:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7, 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 579-68-1896 68 1940 Director Mexico Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar is until by multibut 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 538 Carousel Court 20877 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2.2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1XIYes 2 □ No Specify: \$ Specify: 3 Widowed 4 Divorced Mexican White Completed 16b. Kind of Business/Industry Commonwealth of 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Puerto Rico Driver Pages 1 and 2 should be filed v ment of Health and Mental Hygic ant: If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francisco Dela Rosa Anna Colmenares ၉ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau once. Maria I. Castillo De Dela Rosa 538 Carousel Court, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cematery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State October 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (SpeCity) 26, 2008 Crematory Alexandria, Virginia of Funeral Service Locer 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part 1. Enter the disease shock, or healt failure. Approximate Interval Between Onset and Death **Physician** ule My disease or condition resulting in death) houv /Medical Due to (or as a consequence o): Examiner Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dus to (or as a nonsequence of) law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. ed by the □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ sigr. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy Hospital or Attending Physician: The performed' Division of Vital 1 ZYes 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD Suite Mendhe ratte 2401 31. Date filed (Month, Day, Year) OCT 2 4 Règistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#19 bper FH, 10/27/08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 12:35 PM Junie Dargan October 21. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. t M 2 □ F 215-12-1740 Director 93 4/12/1915 SC Usual Residence of Decedent 10h County 10c. City. Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its its item is a reminer must be notified at Director Y□Yes 2□No DC WAshington none 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 763 Princeton Place, NW Funeral 20011 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2▼INo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No ģ Specify **Black** Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Maryland National Elementary/Secondary (0-12) College (1-4or 5+) Capitol Park & Planning Commission 2nd Supervisor Maintenance s 1 and 2 should be file f Health and Mental H tem 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Dargan ဂ္ Everlina Dargan 19b Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Rawlins/Son 411 Lund Place permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 8 Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cem 10/27/08 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street, NW Washington, DC 20011 23a. Rart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multi Organ Failure Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction Days Sequentially list conditions, Examiner Due to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed sician and burial-trans Arrythmia Days Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? -Bivision of Vital Records, <u></u> been signe should be c 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 🙀 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

e Hospital C. 24 hours after death.

he Funeral Director: Aft Hospital To the within 2

> State Registrar

29b. Signaty

31. Date filed

1500 Forest glen and Silver Spring mo 20910. AHMED NAWAZ 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year) 10-21-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 27, **Physician** 2008 Elwood Roger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 441 Vermont Avenue Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 1 X M 2 ☐ F 79 Yrs 218-24-7566 Director 20,1929 June Usual Residence of Decedent 10b. County show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ihe Medical Exon. The must be notified at Director Maryland Washington Hagerstown 1⊠Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 441 Vermont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No 1943; If Yes, Give Year or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1947**-**1950 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐Yes 2 X No Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) warehouse manager paint and glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy E. Davis Zola Frances Bitner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 Vermont Avenue, Hagerstown, Maryland Joyce P. Davis - wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 27,2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kalut East Wilson Blvd., Hagerstown, Maryland 21740 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) the 1 ☐Yes 2 ☐ No detached 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed 2 🗆 No 1 □ Yes 2**** 2/No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only whe) Hospital: 1 | Yes 2 | 1 | M6 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after comments. After the Funeral Director: After tilled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) ERSTUWN. 11-L+ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DAVENPORT PEGGY LUANN October 24 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Memorial Hospita Eastor Tallor Birthplace (State or Foreign Country)
 Maryland f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖾 F 220-68-7516 50 July 16, 1958 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Experiment by multifuld at 1 Yes 2 No Maryland Hurlock Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21666 6531 Cabin Ridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Waryland 21215-0036 1 ☐Yes 2 🖾 No Specify Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Disabled 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patsy Harbaugh Luther R. Sterling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6531 Cabin Ridge Road - Hurlock, MD Patsy S. Murphy (Mother) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/25/08 Salisbury, MD Salisbury Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licysc e Mary Beth Bradshaw 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Proaably **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any leading to minimal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The to the as a consequence of law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) signed by the signed be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 25100 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital

Dovempor

completely

29c. License number

1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D00 53116

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

219 S. Washington St. - Easton, MD 21601 M.D. Dennis Deshields,

31. Date filed (Month 2003

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

Restrar's Signature

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

-OF

2

Year)

NO1714

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Patrick Corey Dawson	State of Maryland / Department of Health and Menta

	1- For State Registrar	Certificate of Death	Reg. No.	2008 3552
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last) Patrick Corey	/ Dawson	2. Date of Death Month Day October 28, 200	
	4a. Facility Name (if not institution, give street and number) 304 Bayly Avenue	4b. City, Town, or Location of Cambridge		County of Death prchester
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 219-62-9268 1 M 2 F	yrs. last birthday) If Under 1 Year If Under 54 Yrs. Months Days Hours	24Hrs. 8. Date of Birth (MM/D Min. 7/24/195	DDYYYY) 9. Birthplace (State or Foreign Country) Maryland
hours after death with the Maryland natural", or items 23a or 28a-f show any. Caniner must be notified at once.	Maryland Dorchester 10e. Street and Number 304 Bayly Avenue 11. Marital Status 1 Never Married 2 Married Armed Forces?	if Yes, specify Cuban, Mexican, F	10g. Citiz	en of What Country? USA 14. Race - American Indian, Black, White, etc.
7 1 2	3 Widowed 4 Divorced If Yes 2 If Yes 3 Widowed 4 Divorced If Yes for Dates: 15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+)	ted) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	nd of work done 16b. Ki	Specify: White ind of Business/Industry Shellfish
	12 17. Father's Name (First, Middle, Last) Harold Dawson	Waterman 18.Mother's	Name (First, Middle, Maiden S	Surname)
MD and 2 sho alth and m 27 is aumati	19a. Informant's Name/Relationship (Type, Print) Brandy Lynn Dawson / Daughter		er or Rural Route Number, Cit dville Rd., Toddville,	y or Town, State, Zip Code)
Baltimore, I permit. Pages 1 and Department of Heal Important: If item injury or other tra	20a. Method of Disposition 1	20b. Place of Disposition (Name of cemetery, crematory or other place) Mid Shore Cremation Center 22. Name and Address of Facility Curran-Bromwell Funers	10/31/2008	Cambridge, MD
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	death. Do not enter the mode of dying, such as car rotic cardiovascular di	rdiac or respiratory arrest, sho	
ted 	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			
760, icate be execuphysician and the burial - tra	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the little birth and the past 12 months?	2 Fetal death 3 Ectopic	23d	d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death be	ut not resulting in the underlying cause given in Par		use contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physiciau: The law requires that the rs after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Rec ysiciau: The l his certificate h director, page	25. Was case referred to medical examiner?	26.Place of Death (2 ER/Outpatient 3 DOA Other		ence 6 V Other: Scene
ion of Virtending Physicath. Incrementation: After this the funeral direction: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year	28b. Time of Injury 28c. Injury at Work?	28d. Describe how inju	<u> </u>
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:	4 Homicide Could not be determined (Specify)	y - At home, farm, street, factory, office building, etc	or Town, State)	nd Number or Rural Route Number, City
To the Hos within 24 h To the Fut completely	29a. Certifier 1 Certifying Physician: To the best of my king one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier,	nowledge, death occurred at the time, date and place the lation and/or investigation, in my opinion, death occurred 29c, License number	surred at the time, date and pla	d manner as stated. ace, and due to the cause(s) Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of dea	O.C.M.E.		ober 29, 2008
	Ling Li, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2120	01	
State Registra	SULTY IT 7 / / III V AREA	Signature Apple Control of the Contr		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Maryla	nd / Departme	ent of Health and	d Mental Hyg	giene nna	35526
			1 - State Registrar		Certifica	ate of Death	F	Reg. No.	00020
	Physici	an	1. Decedent's Name (First, Middle, Las		UFFIN		2. Date of Dea Month	Day A Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give			ity, Town, or Location of De	10	19 2008 4c. County of Deal	
1	Examin	er	SHADY GROVE	^ - 11	1 AT 1)	MARYLAN		DOMERY
	Funeral		5. Social Security Number 6. Security Number 11		Month	der 1 Year If Under 24 H		h 9 Bir	tholace /State or Foreign
	Director		NONE 1.	X 201	Yrs.	ns Days Hours M	(Month, Da)	-2008 N	ARYLAND
	yland how		10a. State 10b. County		ity, Town or Location		··		10d. Inside City Limits
	88-f s	ctol	USA/MD MONTG	omery K		E, MARYLA			1. No 2 No
	with the	Dire	10e. Street and Number	FT BLVD#		Zip Code	0	10g. Citizen of What Co	ountry?
	death me 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame	
9	or ite	y Fui	Never Married 2 Married	1 Tes 2 No	- 17	pecify Cuban, Mexican, Pu 3 2 ⊈ No <i>Specify:</i>	erto Hican, etc.)	Specify: D	e, etc.
21215-003	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or teme 23a or 28a-f show int, the Madical Exeminer rust be multied at	ed by	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a. Decedent's U	N		16b. Kind of Business	ACK.
2 <u>1</u> 5	hin 72 s. sn "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. DO NO	work done during most of v Tuse retired)	vorking		
7	ygiene ygiene yer the	Con	Ø	Ø		INFANT		INFA	NT
and	intal H ed ott	Be	17. Father's Name (First, Middle, Last) HAROLD ROBIN	DUFFIN	TO	200	lame (First, Middle,		ANCE
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show way figury or other traumatic event, the Madical Examiling in use to notified at once.	안	19a. Informant's Name/Relationship (7			ess (Street and Number or			7
	and 2 ealth a n 27 la		MONIQUE MANCE	 			1D. \$6109	, Rockville	E, MD 20850
altimore,	Pages 1 nent of Ho int: if Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐	Removal from State	Place of Disposition (/ cemetery, crematory of	or other place)	Date	20c. Location - City or	
	permit. Page Depertment of Important: if eny injury or once.		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		ERI CYC	and Address of Espility		HALL RIVE	
Ba	Perm fimpo		· Debra !	10162	SGAH		A CENTOR	DRIVE KOK	VILLE, MD
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a EXTREM	IE PREMI	ATURITY			Onset and Death
	/Medical Examiner		resulting in dea(ii)	Due to (or as a conse					
L		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of).				
	ecuted and transli	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	ficate be executed physicien end s the burial-transit		rosuling in deathy cast	Due to (or as a conse	quence of):			1/1	
687	ificate g phys	edical		d					
Box	eath certifi attending p	an/M	230. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		pregnancy		23d. Date of de	
o.	The law requires that the death certifi lie hes been signed by the attending i page 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of a				Month	Day Year
۵.	res thet the de signed by the a be detached f	y Ph	Part II. Other significant conditions co	intributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	w requires been sign should be	ed by					1 🗆 Y	′es 2 □ No 3 □ Pr	obably 4 DUnknown
ဝ၁	he law re hes bee	Completed					24a. Was a		utopsy findings available completion of cause of
<u>=</u>		So					perfor	rmed? death?	2 □ No
<u>≅</u>	Attending Physicien: Thir death. ector: After this certificete by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	3500	Othor	eath Check only or	30/2	
0	ding Phys h, After this funeral di	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. fnjury at Work?		lence 6 Other (Spe low injury occurred	cify)
Sior	Attendin death. ctor: Afi y the fur	atio	1 Natural 5 Pending investigation		fnjury M	1 Yes 2 No			
Division of Vital	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At h building, etc. (Speci	nome, farm, street, fact ify)	ory, office	28f. Location (S City or Tow	Street and Number or Ri m, State)	ural Route Number,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phy	sician: To the best of my kn	owledge, death occurre	ed at the time, date and pla	ce, and due to the o	cause(s) and manner as	s stated.
	the Ho in 24 I the Fu pletely	Medicai	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	ation and/or investigati	on, in my opinion, death oc	curred at the time, o	date and place, and due	to the cause(s)
١	Veith To 1	≥	29b. Signature and title of certifier		1	29c. License number		29d. Date signed (Mont	
,			30. Name and address of person who o	ompleted source of death (the	m 23a) (Type D-i-t)	D006548		10/19/200	08
			JESSICA HENRY,	MD, SGAH, 9	901 MEDIU	DOOGS98 AL CENTER DA	RIVE, ROCK	KVILLE, MD	20850
	Sta Registr		31. Date filed (Month, Day, Year)	32 degistrar's Sign	ature	30		-1,1,	
100	41-1:15T	-1	14114 11 / 21	TOUR ALEMENTANCE	The state of the s				

	-	For State Registrar		Ce	rtificate of	Death	Re	g. No 2008	35527		
Physicia	n	1. Decedent's Name (First, Middle, Las	,				2. Date of Death Month	Day Year	3. Time of Death 9:00 P		
/Medica	al	Walter		lis	Ab City Town o	- Logation of Dooth		23,2008 4c. County of Deat	141		
Examine	er	4a. Facility Name (If not institution, give Charlotte Hall		3	1	r Location of Death tte Hall		St. Mary			
Funeral Director		5. Social Security Number 6. Social Security Number 212–16–9433					8. Date of Birth February	9. Bir Ye q () 1915 Co	thplace (State or Foreign buntry) orth Carolin		
and w	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation				10d. Inside City Limits		
or 28a-f show	Director	Maryland St. Mar			te Hall		100	- C'	1 □ Yes X No		
th with the 23a or 2		10e. Street and Number 29449 Charlotte Ha	ıll Road		10f. Zip Code 20622	:		g. Citizen of What Co USA	ountry?		
Irs a	by Funeral	11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced	12. Was Decedent Ever in U. Armyed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Black Specify:		
thin 72 ho ne. wan "natur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) unknown	lucation de completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire I tritionis	during most of worl d)	king	6b. Kind of Business, Crownsvil. State Hos	le		
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the				NU	ICT1C10H18		e (First, Middle, M.		htrat		
d be fi	Be	17. Father's Name (First, Middle, Last) Frankie Ellis					(Unknown)				
should and Mer is marke	၉	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street			City or Town, State, .	Zip Code)		
1 and 2 s Health a em 27 is ither trau		Rebecca Cranston			*			dtown, MD			
Page nent o int: If iry or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State Rri	Place of Disponentery, cre nsfie	position (Name of ematory or other place d-Echols	('trom	ctober	Oc. Location - City or Charlotte			
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	See 172					Chols F.H lotte Hal	., P.A., 1, MD 20622		
Physician /Medical Examiner	er	23a. Part 1. Ent the disease, or complished, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	plications that caused the deat one cause on each line. a. PROST Due to (or as a consequence) Due to (or as a consequence)	ATE uence of):	CANC		or respiratory arre	st,	Approximate Interval Between Onset and Death		
ificate be executed physician and is the burial-transit.	cal Examiner	Sequentially list conditions, if any, leading to immediate auco. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of 9	death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	elivery Day Year		
w requires that the d	by	Part II. Other significant conditions of ALZEMIER'S	ontributing to death but not res	-	underlying cause giv	ven in Part I.			o the cause of death?		
t: The law requires t icate has been signe page 2 should be o	Completed	ESSENTIAL H	44 PERTENS	NOI.			24a. Was an autopsy perform 1 🗆 Yes 2	prior to	utopsy findings available completion of cause of s 2 No		
siciar certif rector	Be	25. Was case referred to medical examiner?	Hospital:		Ott		th (Check only one				
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To	1 Yes 2 Oo 27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	of 28c. Inju	4 L9 Nursing n	ome 5 ☐ Resider	nce 6 ☐ Other (Spewin)ury occurred	ecify)		
tal or Atte 's after dea al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, s fy)	treet, factory, office		28f. Location (Str City or Town,	reet and Number or F , State)	lural Route Number,		
ne Hospii n 24 hour se Funera	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, dea ation and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)		
To the To the Complex	ž	29b. Signature and title of cartifier			29c. Licen		29	d. Date signed (Mon			
		thulles	- , MD		D6	7788		10-24	- 2008		
			KODALI		e, Print)						
Stat Registra		31. Date filed (Month, Day, Year) OCT 2 7 20	37 Registrar's Signa	ature	all!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ii yiai iu		tificate of	Death		Reg. No. 2	908	35528
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	ath Day	Year	3. Time of Death
1	/Medic	al	Daniel 4a. Facility Name (If not institution, give	J.			Flint		10	21 0	ty of Death	08:46
	Examin	er		L MIBHAL	Pans		4b. City, lown, oi	Location of Death	/		HICOMIC	٥
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		-	ace (State or Foreign
	Director		333-24-3401	M 2□F	80	Yrs.	Months Days	Hours Min.	7-4-192		New	* *
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	pation				10	d. Inside City Limits
	Maryl fed	ţō	MD Wicomico	,	De1m	ar						1 □ Yes 2▼ No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of	f What Count	ry?
	th with	Funeral Director	8701 Linden Court				218	375		USA		
	r dea	nuel	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - America ack, White, e	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Exerciting rough be notified at once.	Completed by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		□Yes 2√ No	Specify:			ity: Whi	
5-0	72 h	etec	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>		16a. Deced (Give	lent's Usual Occup kind of work done	ation du <i>ring most of work</i> d)	ing	16b. Kind of I	Business/Ind	ustry
121	within iene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)		er/Operat			Floor	ing Co	ompany
d 2	filed Hygi other ent, L	Be Co	17. Father's Name (First, Middle, Last)			OWII	ст, орста	18. Mother's Name	e (First, Middle,			mp carry
ılan	ould be f Mental I arked of atic eve	70 B	Joseph		Flint			Cora		Lu	ther	
Maryland	shou and h is ma auma		19a. Informant's Name/Relationship (Type. Print)			-	and Number or Rui		-		Code)
	1 and 2 Health em 27		Joan Flint - Wife			~~~		ourt, Deli				
ore	Pages 1 nent of H int; If Ite		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐				sition (Name of natory or other plac	i	Date	20c. Location	,	
Baltimore,	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	<u> </u>	Crem		of Delma . Name and Addre	arva 10-2		Delmar		aware
Ba	permit. Departr Importa any inji		11/1/15:0 Hoo	Wy Blow	bo			n Street	unds Fu . Salish			nd 21804
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	of cations that caused one cau	the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
- Mary	Physician		Immediate Cause (Final disease or condition	Ref	racti	100	11/6	as disc	X-	rest		Onset and Death
	/Medical Examiner		resulting in death)	Du tu (or as	a conseque	nce ef).	1/0	\ (1	1	(P
		er	Sequentially list conditions,	b. Du (or as	Conseque	nce of):	12/	5 With	112			m
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (See See See July)	No.	J 60	~~ : C	\tilde{c}	RDUM	0 203	The		
oʻ	e exectant and		that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):				1		
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Medical		d. X	361							
9 X	certific Iding p	/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	:v				004 0) 	
Box	leath cer attendin I for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant al	2 🗀 Fetal d	eath 3	Ectopic pregnanc Other (specify)	у			ate of delive Month	ry Day Year
P.O.	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown								
S, F	es tha igned be det	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ng in the ur	iderlying cause giv	en in Part I.				e cause of death?
Records,	w require been si should t								1 🗆)	Yes 2 □ No	3 Prob	ably 4 🗗 Onknown
Sec	has b	Completed							24a. Was autor	osy	prior to con	osy findings available npletion of cause of
alF	iclan: The law certificate has bector, page 2 s								1 □ Yes		death? 1 ☐ Yes	2 🗆 No
Vital	sician: certific irector,	o Be	25. Was case referred edical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	- 1 D	2/Outpation	t 3 DOA Oth	er:			Wh (0 - 17	
	g Phys er this eral dii		27. Manner of Death	28a. Date of Inju (Month, Day	ry 2	8b. Time of	28c. Injur	y at	ome 5 Resident			"
ior	Attending For death. sctor: After by the funera	atio	1 Natural 5 Pending investigation	1	, rear)	Injury	M 1 🗆	Yes 2 □No				
Division	il or Attend after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At hom c. (Specify)	e, farm, stre	eet, factory, office		28f. Location (3 City or Tov	Street and Nun vn, State)	nber or Rura	Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1. Certifying Ph	ysician: To the best	of my knowl	edne death	occurred at the ti	ne date and place	and due to the	cause(s) and	manner as si	ated
	e Hos 124 hc e Fun letely	Medical		niner: On the basis of	f examination							
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Me	29b. Signature and title of certifier	VAT	_	-	29c. Licens			29d. Date sign	ned (Month, L	Day, Year)
			1 / 1 /	1	1	m)	Do	20441			10/2	108
	roln		30. Name and address of person who	completed cause of d	eath (Item 2	3a) (Type,	Print)	1-1 0	1 -1		/	
			DR. Joseph Kark 31. Date filed (Month, Day, Year)	etto f.K.	M. C/	150 Z	c. Carroll	St. Sa	lisbury	mD.	2180	
	Sta Registr		OCT 23 20	008	a l	k A	anti I	(st. Sa				

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State of Maryland / Department of Health and Mental Hygiene 2 0 8

		- 1	State Registrar			Cer	rtificate of L	Death		R	eg. No.		
			Decedent's Name (First, Middle, La	st)				·		2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medica		Iris Elane Fo	oote						October	r 25,	2008	05:30 PM
	Examine	_	4a. Facility Name (If not institution, given	e street and num	ber)		4b. City, Town, or	Location	of Death			ty of Death	
			Sunbridge Nurs				E1kto:		04 Ura			cil	place (Ctate or Femigra
	Funeral		5. Social Security Number 6. 5	Sex 1 □ M 2 🛣 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day,	Year)		place (State or Foreign
	Director		230-38-8062		73	115.				May 12	, 1935	V1	rginia
	pu s	- H	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	show					T2 1 - 4 -							1 □Yes ¾① (No
	the N	Director	Maryland Cecil 10e. Street and Number			E1kto	10f, Zip Code			1	0g. Citizen o	f What Cou	intry?
	a or		8 Daniel Bathon	Drive			2192	1			Unite	d Sta	tes
	eath	Funeral	11. Marital Status	12, Was Dece		S. 13.	Was Decedent of H	lispanic Or	igin? (Sp	ecify Yes or No-			ican Indian,
_	ter d	교	1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐Yes	2 📉 No		If Yes, specify Cuba			Hican, etc.)		lack, White,	
20	al', or	þ	3 X Widowed 4 □ Divorced	If Yes, Giv Year or Da	e ites:		1 □Yes 2 No	Specify			Spec	oify: Wh	ite
2-003e	be filed within 72 hours after death with the Maryland Hylygiene. d other than "natural", or items 23a or 28a-f show event, I'm Hyllon Evaning must be reathed a	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation during mos	st of work	ing	16b. Kind of	Business/I	ndustry
N N	thin 7 e. an "r	ag l	Elementary/Secondary (0-12)	College (1	4or 5+)	life.	DO NOT use retired	1)			_		
V	filed within Hygiene. other than '	S	12				Secretar		er'e Name	(First, Middle,		vernm	ent
and	tal H d oth even	Be	17. Father's Name (First, Middle, Las	t)						,	maidon com	<i>a,,,,,</i>	
<u> </u>	Men Men arke	ဥ	Walter Ball				ng Address (Street			Patton	r City or Tox	un Stata 7	in Code)
Mar	s 1 and 2 should be filed within 7 f Health and Mental Hygiene. "Item 27 is marked other than "rother traumatic event, Item Mod		19a. Informant's Name/Relationship	(Type. Print)		1	James Run						21001
≃ ໜົ	1 and 2 Health em 27 i		Melissa Wassum / 20a. Method of Disposition	Niece	20b. F	Place of Dispo	neition (Name of	-	Octo		20c. Location		
altimore	it of h		1 XX Burial 2 ☐ Cremation 3	☐ Removal from S	State Be	cemetery, cre L Air 1	matory or other plan demorial as	ce)		2008	D 0 1 A	in M	aryland
	it. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Special Signature Lugeral Silvice Light				1.S 2. Name and Addre	_					aryranu
g	permit. Pages 1 and Department of Healt Important: If Item 2' any injury or other once.		21. Signatu - Trugerar Strvic 2-1.	11.									ryland 21901
-			23a. Part 1. Enter the disease, or co	mplications that c	aused the deat								Approximate Interval Between
		5 11	shock, or heart failure. List onl Immediate Cause (Final	y one cause on e	ach line.	Ü		1				- 0	Onset and Death
in a	Physician /Medical		disease or condition resulting in death)	a. 120	or s a consec	to 4	arre.						
7	Examiner				OI -s a consec	querice oi).	~b	di		se			
	ă.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	or as a consec	quence (f):	7						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0									TA
Ć,	exec in an ial-tra	Exa	resulting in death) Last	Due to	or as a consec	quence of):							
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	cal		d									
	rtifica ng ph as th	Medical	IS SEMALE.										
Вох	leath certific attending p	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1 ☐ Live	come of pregn birth 2 Fet	al death 3	Ectopic pregnan	су			23d.	Date of del Month	livery Day Year
О. В	e dea he at ed fo	Physician	in the past 12 months? 1 □Yes 2 No	4 ☐ Preg 9 ☐ Unkr	nant at time of lown	death 5	Other (specify)						,
<u>Ч</u>	w requires that the de been signed by the should be detached	Phy	9 ☐ Unknow Part II. Other significant conditions	contributing to d	anth but not re-	culting in the	ınderlying cause di	ven in Parl	····	23e. Did t	obacco use o	ontribute to	the cause of death?
Ś	res the	Ď	Part II. Other significant conditions	Contributing to a	Datif Dat flot for	Jaking III allo	anaon , mg			1 🗆 '	Yes 2□N	o 3 ∀ P	robably 4 🗌 Unknown
000	requi	ted								04- 144	0	4h Mora a	utopsy findings available
၁ခ	e law has t	lg l								24a. Was autor perfo	osv	prior to death?	completion of cause of
E	: The cate pag	Completed									rmed? 2 X No	1 🗆 Yes	2 No
<u>≅</u>	ician certif rector	Be	25. Was case referred to medical examiner?	Hospital:		3.50/0.4	ot ot ot			th (Check only o		Other (Cae	ocifu)
ot	Phys r this ral dir	은	1 ☐ Yes 2 No 27. Manner of D ath	28a. Date		28b. Time	of 28c. Inju	iry at	Nursing H	ome 5 ☐ Resi 28d. Describe			эспу)
on	ding h. After fune	Ę.	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mor	th, Day, Year)	Injury	Wo	rk? ∃Yes 2[□No				
S	Atten deat ctor: y the	fica	3 Suicide 6 Could not	be 28e. Place	of Injury - At I	nome, farm, s	treet, factory, office					umber or R	ural Route Number,
Division of Vital Records,	lor/after after Dire	Certification:	4 Homicide	build	ing, etc. (Spec	arry)				City or To	wii, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a, Certifier 1 Certifying	Physician: To the	e best of my kr	nowledge, dea	ath occurred at the investigation, in my	time, date	and place	e, and due to the	cause(s) an	d manner a	is stated.
	he Ho in 24 he Fu	edical	(Check only final Medical Ex	and mar	iner stated.								
	To t To t Com	Σ	29b. Signature and title of certifier				29c. Licer	ise numbe		-6	29d. Date s	gried uvion	th, Day, Year)
			Clober	goul	ei		DOC		13	00	10/	2712	.000
			30. Name and address of person will	no completed cau	se of death (Ite	23a) (Type	Print)	Mai	05	it & 1	Eler	, W	D.
			31. Date filed (Month, Day, Year)	ESUYO	Registrar's Sign	nature .	3 30 /						
36.7	Sta	ate	OCT 9 7 200	107	K	Loga	E)						

			For State Registrar	State of M	laryland		artment rtificate				ental Hy	giene Reg. No.	_ U U _	8	35530
		- 14	1. Decedent's Name (First, Middle, L	ast)							2. Date of De	eath			3. Time of Death
	Physic /Medi		Kathleen Phillip	s Gregory						C	octobe	Day r 22			12:10 P M
5	Exami		4a. Facility Name (If not institution, g	ive street and number,)		4b. City,	Town, or	Location	of Death		4c.	County of D		
	* T	*	St. Mary's Nursi				Leon						. Mar		
	Funeral		,	Sex 7. Ag		ast birthday) Yrs.	If Under Months	Days Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Count	
	Director		467-12-8402 Usual Residence of Decedent		87	110.				11	lay 15	, 192	1 0	kla	homa
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Medikal Examiner must be notified at		10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
	Mary Ff sh	ţċ	Maryland St. Ma	rv's	Leo	nardto	ኒኒኒኒ								1X Yes 2 □ No
	h the	irec	10e. Street and Number		1 200	nar a c	10f. Zip	Code				10g. Citi	zen of Wha	Count	ry?
	th wit	a	40913 Starling C	t.			20	650				Unit	ed St	ate	S
	uges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces'		S. 13.1	Was Deced	ent of Hi	spanic Or	rigin? (Spec	cify Yes or No Rican, etc.)	0-	14. Race - A		
98	or It		1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No	i i	1 □ Yes 2		Specify.		, ,		Specify:		
21215-0036	ural ural	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:								1			
15-	"nat	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d e retired	luring mos	st of workin	g	160. KI	nd of Busine	ess/Ina	ustry
12	withi ene. than	E C	Elementary/Secondary (0-12)	College (1-4or	5+)		spers		,			R	etail		
9	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Las	st)			-		18. Moth	er's Name	(First, Middle	, Maiden	Surname)		
an	lid be lental ked	To B	Samuel Dewey Phi	lling. Sr					Ess	ie Le	na Moc	re			
Maryland	shou ind M i mar umat	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Numb		r Town, Sta	te, Zip i	Code)
	alth a 27 is		Amy Bagwell / Da	ughter		40913	Star	ling	Ct.	Leon	ardtow	m, M	arvla	nd 2	20650
re,	of He item		20a. Method of Disposition		20b. PI	lace of Dispo					ate		cation - City		
Ĕ	Page nent int: If		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		, 1	tbrook			1	11/01	/2008	Mit	che11	Co.	, Texas
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Signature of Funeral Service Lic	ensee	Sin				s of Facil	ity Brin	sfield	Fun	eral	Home	e, P.A.
<u>m</u>	e a E E E		Kyle S. Simon	s M01206											Land 20650
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each I	d the death	. Do not ent	er the mode	of dying	g, such as	s cardiac o	r respiratory a	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Metast	atic (Ovaria	n Can	cor							Onset and Death
7	/Medical		resulting in death)	Due to (or as			ii oun								
	Examiner	l.	Sequentially list conditions,	b											
	pe jis	ine	Sequentially list conditions, if any, leading to immediate	Due to (or as	s a consequ	ience of):									
	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):									
8760,	be ey ician buria	E E		200 10 (0) 40	, a 00,100qa	.01.00 01).									
687	phys phys the	dical		d										+	
	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as it	Physician/Me	IF FEMALE:	23c. If yes, outcome	e pf pregnar	ncy							23d. Date of	dolivor	
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pre					'	Month		Day Year
P.O.	the d y the iched	ıysi	1∐ Yes 2 M2 No 9 ☐ Unknown	9□Unknown			(-,								
	uires that the de signed by the a Id be detached f		Part II. Other significant conditions	contributing to death t	out not resu	Iting in the u	nderlying ca	use give	n in Part	l,	23e. Did	tobacco u	se contribut	e to the	e cause of death?
rds	quire; n sign	q p	Coronary Artert	Disease							1 🗆	Yes 2[XINo 3□] Proba	ably 4 Unknown
00	w requir s been si should	lete	Cerebrovascular	Dicasso							24a. Was	an	24b. Wer	e auton	sy findings available
or Vital Records,	The lav	Completed by									auto		prior	to com h?	pletion of cause of
ta	(0 14	a a	Myocardial Infa: 25. Was case referred to medical	rction			-		26 Place	e of Death	1 Yes (Check only		1 🗆	res i	2 □ No
>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 XX No	Hospital: 1 ☐ Inpati	ent 2 □ £	ER/Outpatier	it 3 □ DO.	A Othe	. P.		ne 5∐ Resi		6 FlOther /	Specify)
ō	ding Physician: After this certific funeral director,	ä	27. Manner of Death	28a. Date of Inju	ury	28b. Time of Injury	f 28	Bc. Injury Work			8d. Describe			opeony,	,
Ö		atio	1XXNatural 5 ☐ Pending 2 ☐ Accident investigati		ly real)	пјагу	М		r ∕es 2□	No					
Division	r Atte	Certification:	3 Suicide 6 Could not 4 Homicide determine	20e. Flace of In	jury - At hor tc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (City or To			r Rural	Route Number,
	ospital or A hours after uneral Dire ly filled in by	Cer	_								0.1, 0. 10	,			
	lospi hour uner	cal	29a. Certifier (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my know	vledge, deatl	occurred a	at the tim	ne, date a	nd place, a	ind due to the	cause(s)	and manne	r as sta	ated.
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	fedical	one)	and manner s	tated.						- ut the time				
	To with	Σ	29b. Signature and title of certifier	1	116		290.	License	number			29d. Dat	e signed (M	onth, E	Day, Year)
), /	10		NUCCH	ranol	CKI	<u></u>		305	514	6-M	D	Och	ober	22	2008
16	11/		30. Name and address of person wh						_						,
	100		Dhimitri Gross,		30 Mis		sie D	rive	Leon	nardt	own, M	ary1a	and 20	650	
0	Sta Regist		31. Date filed (Month, Day, Year)		rai s signat مــــــــــــــــــــــــــــــــــــ	1	0								

Certificate of Death

2. Date of Death

3. Time of Death

4:45

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 XNo

Approximate Interval Between Onset and Death

Prince George's

2008

USA

14. Race - American Indian,

Black, White, etc.

Specify: Black

Union

23d. Date of delivery

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

2008

Month

and manner stated.

1. Decedent's Name (First, Middle, Last)

To the I within 24 State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature

HOSS5927

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

OCT 3 1

o L. Hernandez			of Ma	aryland	/ Departi	ment of iicate of	Healtr	and	wenta	ιгιуς	JICI IC		. 7	20	08	35
	Do	or State	ot\		Certif	icate of	Death	-		2.	Date of D		0.			of Death
Physician/ dical Examine		Decedent's Name (First, Middle,La Pedro Luis Her		ez, Jr	•						Month October		800			34 hrs
JICAI EXAMINIC		a. Facility Name (if not institution, g					4b. City, To		ocation of I	Death			4c. County of Prince G			
		4200 Gallatin Street					Hyatts				Data of	Dieth (A		-		(State or Fore
Funeral	5.	Social Sociality Hames	Sex	7. Ag	ge (In yrs. last		If Under Months		If Under 2	Min.				C	ountry)	
Director		579-15-4218	X M 2	F	20	Yr:	3.				Aug.	30	, 1988	S W	asnir	ngton,
	_	sual Residence of Decedent Oa. State 10b. County			10c. City, To	own or Loca	tion									nside City Lim
рм ану	ì							_							1	Yes 2 X
yland a-f sh t ouce	1	Maryland Prince De. Street and Number	.Geo	rge's	<u> </u>	_Hyat	10f. Zip					10g.	Citizen of WI	nat Co	untry?	
he Maryland or 28a-f sh liffed at ouc		5201 42nd Ave	nue					0781					USA			
with the 18 23a ce noti		Mantal Status			t Ever in U.S.	13. W	as Deceder Yes, specify	nt of Hisp	anic Origin Mexican,	n? (Spe Puerto F	cify Yes or Rican, etc.)	No-		e, etc.		lian, Black,
or items 23		1 X Never Married 2 Marri	1		2X No		_						Specify:	TaTh.	ito	
ral", o			ed If Yes, or Dat	95'	melatod\ I1	I6a Decede	Yes 2	Occupation	on (Give ki	nd of we	ork done	10	6b. Kind of B			/
hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)		ollege (1-4 o		during	most of wor	king life.	DO NOT L	se retire	ed)					
36 in 72 than "		Elementary/Secondary (0-12)	,	1			Labor		-						Gove:	rnment
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatte event, the Medical Examiner must be notified at once.	Completed	7. Father's Name (First, Middle, La	ist)					1	8.Mother's	Name	(First, Midd	dle, Mai	den Surname	e)		
215 be file ntal H rked c	%	Pedro Hernand				Vani. 14-70	^ -	(Channi	Jose	fa N	unez	Numbe	er, City or To	wn. St	ate, Zip C	Code)
nould he man tric ev	9	19a. Informant's Name/Relationship														
MD and 2 sho alith and 27 is m 27 is aumati	-	Pedro Hernandez 20a, Method of Disposition	, Sr	./Fatl	20b. Pl	ace of Disp	osition (Nar	ne of cen	netery,		Date	- 13	e. MD 20c. Location	- City	or Town,	State
of Hee		1 X Burial 2 Cremation	3 Re	moval from	o. l cr	ematory or te of	other place)	l.	rv	Oct.		~	~	. •	
Page ment tant:		4 Donation 5 Other Spe	oify:								2008				-	g Mary
Baltimore, Department of Hee Important: If ite Injury or other tr		21. Si ature of Funeral Service Li	1	00.		T.	ranci	s J.	Col	lins	Fune	eral S	Home	In Sp	rina	, MD 2
Physician	\dashv	23a. Part I. Enter the disease, or 6	omplicatio	ns that caus	ed the death.	Do not ente	r the mode	of dying,	such as ca	ardiac o	r respirator	y arres	t, shock, or h	eart	Ap	proximate inte tween Onset
'Medical		failure. List only one cause o Immediate Cause (Final disease	n each iin	е.	ind of Head											Death
aminer	1	or condition resulting in death)			nsequence of											
		Sequentially list conditions,	b.	0.05.00.3.00	nsequence of).										
	mine	if any, leading to immediate cause. Enter Underlying Cause	C.			_										
n _	۵I	(Disease or injury that initiated events resulting in death) Last	Due t	o (or as a co	nsequence of	;);										
ecuted .	Physician/Medical E		d													
760, Scate be exe g physician a the burial -	흻	UNPENDED		ENDED		22201							23d. Date	of de	ivery	
Box 68760, c death certificate buthe attending physic ed for use as the buthe	N	IF FEMALE: 23b. Was decedent pregnant in the		Live birth	come of pregr	2	Fetal death	3	Ectopi	c pregn	ancy		Month	1	Day	Yea
X 6. th cert tendin	icia	past 12 months?	4		t at time of de	ath 5	Other (Sp	ecify)				-				
cords, P.O. Box 687 law requires that the death certifith the stending that be detached for use as to should be detached for use as to the stending that th	hys	Part II. Other significant conditi	-			esulting in t	ne underlyir	ng cause	given in P	art I.	1.7					cause of deat
that the opposite of the oppos	by	Part II. Other Significant conditi	3113 0011	and dailing to a							1	Yes	2 🗸 No	3	Probably	4 Unkr
S, Fquires en sign	ted										24a	. Was a		b. We	re autops	y findings av
aw renas be	ple										1	perfor		dea	ith? Yes	2 1
Rec The 1 icate 1	Completed							26 Plac	ce of Death	(Check	only one)					
tal clan: certif	Be (25. Was case referred to medical examiner?	Hosp	ital:	patient 2	ER/Outpa	tient 3	DOA	Other ₄		ing Home		Residence	6 🗸	Other: Sc	ene
Physical direction	2	1 ✓ Yes 2 No 27. Manner of Death		28a. Date of	f Injury	28b. Time		28c. Inj	ury at Wo	rk?			ow injury oc	curred		
rding h. Afte	ion:	1 Natural 5 Pend	ing	FOUND:		FOUND 0033 hr		1	Yes 2	No	Subjec					
Sional Atternation of the state	icat		tigation	Oct 22, 20 28e. Place	of Injury - At h	nome, farm,	street, facto	ry, office	building,	etc.	or T	Out S	tate			Route Numbe
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Certification:	dete	d not be mined		Local Stre						4200 G	allatin	Street, Hya			
Hospi 24 hou Funer ely fil	Š	20 O-#F-4	nysician:	To the best	of my knowled	dge, death o	occurred at	the time,	date and p	olace, ar	nd due to th	ne caus	e(s) and mar	nner a	s stated. e to the ca	ause(s)
To the I within 2 To the I complet	Medical	(Check only one) 2 Medical Exa	miner:On	the basis of d manner sta	examination	and/or inves	stigation, in	my opinio	on, death o	occurrec	acore unit	_, uate	and place, o			Day, Year)
	63	29b. Signature and title of certific			-		13	29c. Lice	nse numbe	31			Zou. Date	9-100	- (incline)	- 0,,, 000)

State 31. Date filed (Month, Day, Year) 100 2 4 2008

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registrar

October 22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Ma	iryland / De $\mathcal{C}\epsilon$	partment of h artificate of i		Mental Hy	giene Reg. No.	Z U U (35533
		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	eath		3. Time of Death
Phys /Me	ician dical	ALEXANDER		H	AWKINS	S	Month OCTUBE	Day 24		6 08 1BM
Exan		4a. Facility Name (If not institution, give				r Location of Dea			County of Deatl	1
		The Johns Hopkins H			Baltimore					
Funera		5. Social Security Number 6. S	ex 7. Age M 2 □ F	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hr Hours Min	(Month, Da	rth ay, Ye <i>ar)</i>	9. Birti	nplace (State or Foreign intry)
Directo	r	173-20-4055 Usual Residence of Decedent		_83 Yrs.			Januar	y 1	1925 Pe	nnsylvania
yland how		10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
Mar a-fs	cto	Maryland Washingt	on	Hagersto	wn					1 Tes 2 No
or 28	Director	10e. Street and Number			10f. Zip-Code			10g. Citiz	zen of What Cou	intry?
ath w 23a ust b		10930 Roessner A			21740				U.S.A.	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thyer than "natural", or Items 23a or 28a-f show in, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 🕅 Married	12. Was Decedent E Armed Forces?	ver in U.S.	. Was Decedent of H If Yes, specify Cuba	tispanic Origin? (an, Mexican, Puer	Specify Yes or No rto Rican, etc.))-	 Race - Amer Black, White 	
336	b y	3 Widowed 4 Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 X No	Specify:			Specify: LTh	ite
5-0036 72 hours aft natural", or IIcal Examir	De de	15. Decedent's Ed	Jucation	16a. Dec	edent's Usual Occup	oation		16b. Kii	ind of Business/	
215 Hin 7	Completed	(Specify only highest gra	College (1-4 or 5-	lite	e kind of work done DO NOT use retired	duning most of wo d)	orking			
d 2121 filed within Hygiene. other than "	් දු		4	Tea	cher	1			ucation	
rland Iland	æ	17. Father's Name (First, Middle, Last)	leina				ame (First, Middle	e, Maiden	Surname)	
aryla should I and Meni s market umatic e	ပု	19a. Informant's Name/Relationship		40h 44a	lim A el elma a /Dhan	Lola P		0'/	T . D	0.11
<u></u>					ling Address (Street				,	p Code)
e, N 1 and 2 Health tem 27		Gloria V. Hawkin 20a. Method of Disposition	s/Wire	20b. Place of Dis	30 Roessno	er Ave.,	Hagerst		MD 21 cation - City or	· · · ·
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		1 X Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		Rest Has	osition (Name of ematory or other place yen Cemete	ce) erv :10/			erstown	
nit. Partme	اند	21. Signature of Funeral Service Licens	*		22. Name and Addre					
a med me	5	12 - 6/3	~~~		1601 Penns					
		23a. Part 1. Enter the disease, or company shock, or heart failure. List only of	olications that caused	the death. Do not e	nter the mode of dyin	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			SHOCK					Onset and Death
/Medica		resulting in death)	Due to (or as a	consequence of):	31.001					
LAAIIIIIC		Sequentially list conditions,		WINAL	INFARC	TION				
pe jisit	T in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					1	
xecut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
COIdS, P.O. BOX 68/6U, v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		d.							
GC/ tifficate g phy as th	Med							1		
BOX I	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnanc	av.		2	23d. Date of deli	
death re atten	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown		Other (specify)				Month	Day Year
at the of the detache		Part II. Other significant conditions c	ontributing to death bu	it not resulting in the	underlying cause of	iven in Part I	220 Did	labassa u	una contributa to	the cause of death?
requires that the sen signed by the hould be detached.	d by		orang to doday be	it not roosising in the	andenying cause gi	von in rait i.	1 🗆			bably 4 \Unknown
ecord aw require s been sig	Completed					-	24a, Was		1	opsy findings available
has be 2	E G						auto perfo	osy ormed?	prior to death?	completion of cause of
VITAI slcian: Th certificate irector, pa		25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o	2 No	1 Tyes	2 🗌 No
Of VICE Physician: this certifical director,	To Be	examiner? 1 N Yes 2 No	Hospital: 1 Napatier	t 2 ER/Outpatie	nt 3 DOA Oth	or.	Home 5 Resi		3 ☐ Other (Spec	fv)
– – – –		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	/ 28b. Time		y at	28d. Describe			<i>"</i>
Attending or death. Bector: After by the fune	atic	2 Accident investigation		,		Yes 2 No				
or Attending after death. Director: After lin by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	y - At home, farm, s (Specify)	reet, factory, office		28f. Location (City or Tox		d Number or Ru	ral Route Number,
oltal c		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, dea	th accurred at the tir	ma data and also	and due to the	(-)		
TO the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Medical	(check only one)	niner: On the basis of and manner state	examination and/or i	nvestigation, in my c	opinion, death occ	c, and due to the curred at the time	, date and	and manner as d place, and due	to the cause(s)
o the vithin o the	Me	29b. Signature and title of certifier			29c. License	e number	T	29d. Date	e signed (Month	Day, Year)
F > F 0		Atau Wo	M.D.		050	-000		BOT	erino a	4,2008
		30. Name and address of person who		eath (Item 23a) (Type	7 - 4			۱۱ ناپ	-501- 6	.,,,,,,,
3H 471		STALY WAN		_		600	North Wo	lfe St	t, Baltimo	re, MD, 21287
S Regis	tate	31. Date filed (Month, Day, Year) OCT 2 9 20	32. Registrar	's Signature	land.					
negis	arell.	001 20		as AF A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kathy N. Hall October 2008 3:15 P.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 | M 2 | F 219-82-0982 45 September 27, 1963 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X1No Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 318 Key Avenue 21225 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ∐Yes 2X No 1X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Dialysis Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Audrey Ann Chew Albert T. Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monique Sellman - Daughter 6 Ellington Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery 10/23/2008 Sunderland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slades a. Sewell Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery death 3 Ectopic pregnancy 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner requires that the death certificate be executed and

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Physician

/Medical

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Funeral

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28a-f show

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ir than "natural", or items 23a or 28a-f showing Medical Evaninar ir ust be notified at

within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Ma

Baltimore, Maryland 21215-0036

P.O. Box 68760.

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Physician:

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After this

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To the Funeral Director: After thi
completely filled in by the funeral

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23h.

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EMALE: Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ma No	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de 9 □ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

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27. Manner of Death	
1 Natural	5 Pending
O D A soldons	investina

28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred

nvestigation 6 ☐Could not be 3 Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier (Check only one)

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signat Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State

MD OU 31. Date filed (Month, Day,

OCT

Anne An 32. Registra s Signature

and manner stated

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 9318 M YVONNE **ELIZABETH** HILL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death REGIONAL SAL1564K4 reninsum Niconico MOKAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Vest Virginia Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 232644453 1 □ M 2 🔀 F Months Hours 67 Oct. 4, 1941 West Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 U.S.A. 26517 Mariners Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 ☐ Yes 2 🛛 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Armstrong Helen Barnabi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George L. Hill (Husband) 26517 Mariners Road - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/24/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic , see 22. Name and Address of Facility Bradshaw & Sons Funeral Home Both Bradshaw Pruitt 306 W. Main St. - Crisfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMALL AND OF a GANGRENE LARGE 3 days disease or condition resulting in death) Due to (or as a consequence of): HEROSCLEROMA MESENTERIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown FIBRILLATION Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical

Physician /Medical Examiner law requires that the death certificate be executed

Physician

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If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, "the Modical Examiner must be notified at

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Baltimore, Maryland

Box 68760,

P.O.

Division of Vital Records,

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27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At I building, etc. (Spec	home, farm, stree	t, facto	ory, office		 Location (Street and Number or Rural Route Number City or Town, State)

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est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) stated.

MD

29d. Date signed (Month, Day, Year) D 41567

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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21801 15 E. CARROLL SAUSBURY NICHOLA 31. Date filed (Month

State Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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			Department of Health and Mental F			lygiene 2008 35536					
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Funeral Director		5. Social Security Number 6. Sex 7. A 1 M 2 □ F	ge (In vrs. last birt	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea July 3, 19	r) Co	hplace (State or Foreign untry)			
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arylan show	Ž	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
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(4)		30. Name and address of person who completed cause of MARA BARON, M.D. 3.	death (Item 23a) ((Type, Print) 1/2 om 5	1. 1/ac	Sand 1	00017	10			
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Physician /Medical Examiner

For State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine riset be nutified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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	> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	NYG	anin			I	04116	52			0c	tobe	r 23	, 2008
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:55 P M 2008^{eai} 28, October John Harrison Insley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Shores Nursing Center Lexington Park St. Mary's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1₺ M 2□ F 218-14-2167 94 Director August 16, 1914 Maryland Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examinar must be notified at Director 1 □Yes 2X□No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45341 Nats Creek Road 20636 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No If Yes, Give Year or Dates Specify þ Specify: USA 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Owner/Operator 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edward Insley ပ္ Margaret Edith Abell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45341 Nats Creek Road Hollywood, MD 20636 Scott Michael Insley 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State November 3, Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Kenne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the wode of tening, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician the burial Physician/Medical use as attending properties of IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) ed by the a 1 □Yes 2 □ No. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate ! perform 1 ∐Yes 2 🗆 No 2 funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred ospital or Attending I hours after death. 1 Natural 5 ☐ Pending investigation neral Director; A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital

Saltimore, Maryland 21215-0036

certificate be executed

Box 68760.

P.0.

Division of Vital Records,

State Registrar

completely

DHMH 17 Rev 1/2001

(Check only one)

30. Name and address

24035 Three

31. Date filed (Month.

29b. Signature and title of certifier

person who completed

Notch Road

ay, Year

Hollywood, MD 20636 Registrar's Signature

ause of death (Hem 22) (Type, Print) James Patrick Jarboe, M.D.

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per phys. G888 2/12/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gladys Louise Jenifer $20^{\text{Day}}, 2008^{\text{Ba}}$ Oct. 1527 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | A u g • 30, 19 2 5 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 M.D. **Funeral** 1□M 2♀F 218-24-3581 83 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Madical Examiner must be notified at Prince Frederick Calvert 1 Yes 2X No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2260 Grays Road 20678 USA 238 Funeral Pages 1 and 2 should be filed within 72 hours after death Items 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or Specify Black 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0wen Holland Ethe1 Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health an Important: If Item 27 le any injury or other trausons. Elizabeth Brooks/Daughter 2114 Adelina Road Prince Fred., MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chelt. Vet. Cem. 10/29/08 4 □ Donation 5 □ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licenspe 22 Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road 20678 Madys 9. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** mun /Medical Obstructive Due to (or as a consequence of): Examiner Uropathy للحك Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Nephrolithiasis days Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) O 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes 2 No To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2 No Hospital: Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature, and title of quitifier 29c. License number 29d. Date signed (Month, Day, Year) D67647 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK, 20678 ROAD

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State Registrar 31. Date filed (Month, Day

2008 Registres Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hugh Lawler Johnson III 10/23/2008 3:55 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7/9/1947 ACountry) Months Days Hours Min 212-50-1965 Director 61 Usual Residence of Decedent Worcester 10a State show 100 City, Town & Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Wedical Examination for items Director 1 ☐ Yes 2XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 USA 515 Sandy Hill Montego Bay Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 XNo White þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Heath and Mental Hygien.
Important: If item 27 is marked other the any Injury or other traument. Bartender Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Lucille Sherrill Hugh Lawler Johnson, JR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Sandy Hill Montego BAy, Ocean City, MD 21842 Tammy Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/24/2008 Frankford, DE Cape Henlopen Crem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burbage Funeral Home 108 Williams St. Berlin, MD 21811 Part 1. Enter the disease shock, or heart failure. I or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner o (or as a consequence of) be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

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Johnson, Mar

31. Date filed (Month, Day, 2 4 2008

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29b. Signature and title of certifie

sairer

Registrar

29c. License number

053612

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08149 State of Maryland / Department of Health and Mental Hygiene William Kemerer Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 30, 2008 Year 1515 hrs William Lee Kemerer **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Carroll Westminster Carroll Hospital Center Date of Birth (MM/DD/YYYY)Birthplace (State or if Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** oreian Months Davs Min Country) Pennsylvania Director 207-46-7273 Yrs X M 2 F 53 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1X Yes 2 No is 23a or 28a-f show a Maryland Carroll Taneytown imore, MD 21215-0036
Pages I and 2 should be filted within 72 hours after death with the Maryland neat of Health and Mental Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21787 537 Trevanion ā Terrace 14. Race - American Indian, Black; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Examiner must be Armed Forces 1 Never Married 2 X Married Yes Yes 2X No specify: Specify: White If Yes. Give Year Divorced Widowed à 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Construction Truck Driver 12 18.Mother's Name (Firşt, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise McCabe is marked Be Robert Kemerer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21787 19a. Informant's Name/Relationship (Type, Print) Trevanion Terrace, Taneytown, Maryland Cynthia Lee Barron Kemerer 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) XBurial 2 Cremation 3 Removal from State Greensburg, PA. WestmorelandCo.Cem11-5-08 Donation 5 Other Specify 22. Name and Address of Facility Marzullo Funeral Chapel Road, Baltimore, Maryland21214 21. Signature of Funeral Service Licensee 6009Harford 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician een Onset and Death 'Medical Chronic obstructive pulmonary disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial - transit AMENDED 23a,PII,27,28a-f, perME, G886 12/18/08 TT hysician/Medical X UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 1 Yes 2 No 3 Probably 4 V Unknown ≥ Seizure disorder due to head injury Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy death? performed? certificate has ✔ Yes 2 ✓ Yes No 26.Place of Death (Check only one) 25. Was case referred to medica of Vital Be Other: Hospital: 1 Inpatient 2 Residence 6 Nursing Home 5 DOA ER/Outpatient 3 this 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28h Time of Injury 27. Manner of Death After Certification unk 1 X Yes 2 No Natura Division Pending within 24 hours after death. Director: d in by the unk Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) unk 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide unk To the Funeral D determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 1, 2008 O.C.M.E. Masse 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008 Charles . MOV 0 Registra

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State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Daniel Adam Kurek Oct 22 2008 2130 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 9 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F 9"1919 216-05-7653 89 Maryland Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "naturel", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at Maryland Calvert St. Leonard 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1587 Calvert Ave. 20685 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 □ No 44-46
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Marned Specify: White Baltimore, Maryland 21215-0036 1□ Yes 2HNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Insurance Agent Insurance 12 should be filed w n and Mental Hygier Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eventaging. Adam Francis Kurek Elizabeth Haliniarz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellen R. Kurek- wife P.O. Box 77 St. Leonard MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 24 2008 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Alexandria Virginia Metropolitan Funeral service 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMUNIA 2 DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I arry, ledon of to immodiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HOJGKINS LTMPHOMA CHRU 1 Yes 2 ₩ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No OBSTRUCTIVE PULMONARY autopsy performed? 1 Yes 2 1 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 VIII Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26358 Oct 23 2008 30. Name address of person who complet caus death (Item 23a) (Type, Print) PRINCE FRE DEPICE MY 20678 WEIGEL MIS 31. Date filed (Month, Day, Year) 32. Registra Signature State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Littlejohn October 22, 2008 Marion 11:45 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14712 Spring Meadows Drive Darnestown Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2X F **Director** 347-18-8725 Oct. 11, 1922 Illinois Usual Residence of Decedent be filed within 72 hours after death with the Maryland at Hygiene. 10c. City, Town or Location 10b. County r 28a-f show notified at 10d, Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 14712 Spring Meadows Drive 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XIYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) :. Pages 1 and 2 should be file tment of Health and Mental H-tant: If item 27 is marked oth jury or other traumatic eveni Be P Frederick Christy Marie Lyerla 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curt Littlejohn/Son 14712 Spring Meadows Dr., Darnestown, MD. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Wash. Park North Cem. 10/28/2008 Indianapolis, IN 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. End Stage Kidney Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1☐ Yes 2 X No funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ▼ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 X Natural 5 Pending To the Hospital or Attendin. within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 D 24398 October 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Road, Rockville, Maryland 20850 Philip Schwartz, M.D.31. Date filed (Month, Day, Year) Registrar's Signature State OCT 24 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

COD LINTNICUI	111	R	- For State egistrar		tificate of D		ic Mental H		. No. 200	8 3554
Physic edical Exan	cian nine	-	Decedent's Name (First, Middle,Las Jacob Robert Lin				504.2	2. Date of Death Month October 26,	Day Year	3. Time of Death 2113 hrs
-			a. Facility Name (if not institution, given	ve street and number)			r Location of Death		4c. County of Deat	h ·
/		Ļ	251 East Antietam Street 5. Social Security Number 6. S			Hagerstow If Under 1 Ye		8 Date of Birth	Washington (MM/DD/YYYY) 9, Bi	rthplace (State or
Funera Directo		2	219–33–0735	XM 2 F 16		Months Da		_	Forei	gn Washington ountry) DC
any		T	Usual Residence of Decedent 10a. State 10b. County	•	Town or Location				,	10d. Inside City Limits
fand f show	T I		Maryland Washingt	on Smi	thsburg			140	635	1 Yes 2 X No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. mit: If item 27 is marked other than "natural", or items 23a or 28a-f show Marked recommend to a factor of the Marked of the Marked Feature and the mortfled 24 more			10e. Street and Number 127 Eagles Ridge	:		0f. Zip Code 2178			U.S.A.	
ath with	101 100	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?			lispanic Ongin? (S an, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
after de			3 Widowed 4 Divorce	1 Yes 2 X No	1 Y	es 2X N	o specify:		Specify: W	hite
hours.	- Yall	Led r	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)			ation (Give kind of e. DO NOT use ret		16b. Kind of Business	s/Industry
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours afte nt of Health and Mental Hygiene. tt: If frem 27 is natived other than "natural",	TC.TR.SI	ompleted	11	College (144 di 31)	Stude	nt		0.01	High Sc	hool
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than	9	۱ د	17. Father's Name (First, Middle, Las Danny L. Linthicu					e (First, Middle, M	aiden Surname)	
212. 212. wuld be Menta marke	u c	-	19a. Informant's Name/Relationship (19b. Mailing A	ddress (Stre		R Hunter Rural Route Numb	per, City or Town, Sta	te, Zip Code)
ore, MD 2121! ss I and 2 should be fil of Health and Mental I friten 27 is marked		- 1	Lisa R. Linthicum						MD 21783	Taura Chata
ore, M ges I and 2 of Health If item 2	mer ir		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	Place of Disposition	r place)		Date	20c. Location - City of	
Baltimore, permit. Pages 1 an Department of Hea Important: If iter	6 -	-	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice	Z'	dar Hill		(F	-	Suitland,	
		1	Durcho At	Tury						neral Home , MD 21742
Physicia /Medica			23a. Part I. Enter the disease, or comfailure. List only one cause on e	each line.	. Do not enter the	mode of dyin	g, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xamine	_	1	Immediate Cause (Final disease or condition resulting in death)	Hanging Due to (or as a consequence of	of):			-		Death
	ŀ	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence o	·f)·					-
	1	Examiner	cause. Enter Underlying Cause							
uted	ansıt		events resulting in death) Last	Due to (or as a consequence of	01):					
60, ate be executed bhysician and	ırıal - tı	Medical	UNPENDED	AMENDED					-243	
3760, ifficate by	s the br	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		I death 3	Ectopic pregr	nancy	23d. Date of deliver	ery Day Year
Box 687 death certific	or use a	Physician/I	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of de		r (Specify)				
. 4 -	iched to	Ph	Part II. Other significant conditions	9 Olikilowii	resulting in the unc	derlying cause	e given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
, P.O. res that t	be deta	d b						1 Yes	2 V No 3 P	obably 4 Unknown
ords w requi	should	Completed						24a. Was a autops	sy prior to	autopsy findings available o completion of cause of
Reco	page	E O						perfor 1 V Yes 2		
ital Rec sician: The s certificate	rector	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Other Nurs		Residence 6 ✓ Ott	ner: Scene
		<u></u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inju		njury at Work?	28d. Describe h	now injury occurred	
ttendir death.	y the fu	aţi.	1 Natural 5 Pending 2 Accident Investiga	ation	1900 hrs		Yes 2 V No	Subject foun		
Division all or Attendirs after death.	ed in b	Certification: To	3 Suicide 6 Could no determin			factory, office	e building, etc.	or Town, S		Rural Route Number, City Md.
Division To the Hospital or Attentivition 24 hours after death			4 Homicide 29a. Certifier 1 Certifying Physi (Check only)	ician: To the best of my knowled	ige, death occurre	ed at the time,	date and place, an	nd due to the cause	e(s) and manner as s	tated.
To the within To the	comple	Medical	one) 2 Medical Examin	er: On the basis of examination a and manner stated.	and/or investigatio			at the time, date a		
		Σ	29b. Signature and title of certifier				nse number C.M.E.		29d. Date signed (# October 27, 20	
		-	30. Name and address of person who	o completed cause of death (Iter	n 23a)					
)H-8			Ana Rubio MD. Assist	ant Medical Examiner	111 Penn St	reet, Baltir	more, MD 2120	01		
Reg	Sta jistr	ite ar	31. Date filed (Month, Day, Year) 2	2008 32. Redistrar's Signat	ture.					

STEVEN EUGENE Lanham 08-07813 Please Type or anni in Black Indelible Ink. Ensure All Comes Are Legible. **UNK UNK** haryland / Department of Health and Mental 2008 35545 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 16, 2008 2228 hrs Steven Lanham Eugene Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Waldorf 2400 Old Washington Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Months Days Hours 68 ountry) Director 215-78-7632 1 XM 2 39 November Maryland Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location XNo Yes 2 28a-f shov tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. MD Charles Waldorf death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2400 Old Washington Road 20601 USA 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No White hours after If Yes, Give Year Yes 2 X No specify: Specify: Divorced <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) timore, MD 21215-0036

t. Pages I and 2 should be filed within 72 hou rement of Health and Mental Hygiene.
rtant: If item 27 is marked other than "nan Elementary/Secondary (0-12) College (1-4 or 5+ Night Watchman Security 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Lanham

19a. Informant's Name/Relationship (Type, Print) Francine Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Lanham/Father P.O. Box 42, Cobb Island, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place , Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Crem. 10/31/08 Department of Important: injury or otl Charlotte Hall, MD Donation 5 Other Specify permit. 22. Name HART - ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses M00945 chule St. Mary's Ave. La Plata MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical a Smoke inhalation and thermal injuries Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the Hospital or Attending Physician: The law requires that the death certificate be executed #1,23a,2/,28a-1, permE, g885 11/20/08 TT Physician/Medical X AMENDED X UNPENDED physician a Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Fetal death 3 Ectopic pregnancy Month Day Live birth use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed page 2 should 24b. Were autopsy findings available been 24a, Was an prior to completion of cause of autopsy has death? performed' ✓ Yes 2 2 No No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner' Hospital: 1 Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient ER/Outpatient 3 this 1 V Yes No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28d Describe how injury occurred in house 1 Natural Pending within 24 hours after death.

To the Funeral Director: Fnd 10/16/0B Fnd 2228 hrs fire the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2400 01d Washington 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined (Specify) B1vd residence Waldorf, 4 . Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 17, 2008 O.C.M.E.

State

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

32. Registrar's Signature

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:05 M Octoben 2008 Grace Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL SALISBURG Consu HICOMICO MEDITAL PENINSYVA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🗓 F 078-20-1345 9-26-1924 Director New York Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2X No Director Seaford Sussex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6115 Patrick Court 19973 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2**X** No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Costello Albert ၉ Bierman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Pages 1 and 2 6115 Patrick Court, Seaford, DE 19973 Brian W. Lewis /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Crematory of Delmarva 10-23-2008 | Delmar, Delaware 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee Messa 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 20 tu. DAYS disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. cate has been signed by the a page 2 should be detached to 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ▼Inpatient 2 □ ER/Outpatient 3 □ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After **Division** 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D62107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury mel 21801 Wilhite 100 €. CAPROLL Douglas MD State 23 2008

DHMH 17 Rev 1/2001

Registrar

John Lankford

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Vita

Diviśi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10-22-2008 **Physician** JOHN THOMAS LANKFORD 11:05AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6212 Galestown Reliance Rd Seaford Dorchester If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
12-11-1947 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 221-34-8264 60 Delaware Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 XNo Director Seaford Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6212 Galestown Reliance Rd 19973 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or item any injury or other traumatic event, the Medical Examples. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🌋 No white Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farm Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas T. Lankford Addie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia Lankford - wife 6212 Galestown Reliance Rd, Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory 10/23/2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State Dover, DE 4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral Stroke Cranstonsfülleral Home P O Box 967, Seaford, cranston John A. DE 19973 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** an /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 20 No 은 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Director (Illed in by 4 Homicide 29a. Certifier 妊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 🖊 🗖 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state To the within 2. 29b. Signature 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Costal

State Registrar 31. Date filed (Month, Day, Year)

OCT 23

2008

			1 - For State Registrar	State of Ma	arylar	-	artmen rtificate			and M	lental Hy	giene Reg. No	000	35	548
	Dharaini	ŧ	1. Decedent's Name (First, Middle, La	st)				•			2. Date of De	eath Da	/ Ye		of Death
	Physici /Medio		Charles Edward I				,				Octobe	r 23	, 2008	8:4	6 a.M.
	Examir	er,	4a. Facility Name (If not institution, giv						Location of				County of D	eath	
			Calvert Memorial 5. Social Security Number 6.5		. //	la ad birda da d	Prin If Under		Frede		O. Data of Bir		lvert	District (O)	
	Funeral Director		-	1	8 (III yrs.	last birthday) 6 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 01/14/	1922	Ma	Birthplace (Stat Country) .ryland	e or Foreign
	yland now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits
	Mar illed	tor	Maryland St. Mary	's	Leor	nardtow	m							1 (<u>X</u> Y	es 2 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What	Country?	
	23e	ia	22680 Cedar Lane				206						ed Sta		
	teme	une	11. Marital Status	12. Was Decedent Armed Forces?		l.S. 13.	Was Deced	lent of Hi ofy Cuba	ispanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	0-		merican Indian /hite, etc.	
36	rs aft	y F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ 1 If Yes, Give Year or Dates:	40		1 □ Yes 2	2[X No	Specify:				Specify:	rm .	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther then "netural", or Iteme 23e or 28e-1 show with the Medical Evaninar must be rodified at	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Usua	I Occupa	ation			16b, K	ind of Busine	White ss/Industry	
715	nin 77	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5		(Give	kind of wor DO NOT us	rk done d	du <i>rina m</i> osi	t of worki	ing			,	
2	d witl giene er the	Som	12	College (1-40)	· +)	Machi	nist					Mar	ufacti	ıring	
nd	al Hy a oth	Be (17. Father's Name (First, Middle, Last,)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)		
<u>ya</u>	Ment Ment arke	ပ္	Charles E. Lippy,			-			Viola	a B1:	ick Sap	р			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Evantinal must be notified at anose.		19a. Informant's Name/Relationship (**		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	d Route Numb	er, City o	r Town, Stat	e, Zip Code)	0619
e,	1 and Health		Valerie A. Ham/Da 20a. Method of Disposition	ughter	20h F	23708			uxen		ach Dri			ornia, or Town, State	
Jor	ages nt of h		1 ☐ Burial 2 【XCremation 3 ☐		(cemetery, crer	natory or o	ther plac					•		
Ħ	it. Perintment		4 □ Donation 5 □ Other (Special21. Signature of Funeral Service Licer		Bri	asfiel	d-Ech	ols	Cre 10	0/25	/2008_	Char	lotte	Hall,	MD
Ba	Depa Impo any ir			1/4/2	25									Home,P.	
			Kyle S. Simons 23a. Part1. Enter the disease, or com								d, Leon		own, I	Approxin	nate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	10.			^						Interval E Onset ar	Between nd Death
	/Medical		disease or condition resulting in death)	a. ATTO			OMC	· (0)	chov	osa	ilan o	17:10	use		
	Examiner					,									
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	juence of):									
	sate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c											
90,	oe exe cian a urial-	EX	resulting in death) Last	Due to (or as	a conseq	juence of):									
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d											
9 X	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancv									
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	ıl death 3 []Ectopic pr					,	23d. Date of Month	Day	Year
<u>о</u> .	the d y the iched	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown			2011101 (3)	JUNY							
	s that ned b e deta	y P	Part II. Dther significant conditions	ontributing to death b	ut not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1	tobacco u	ise contribut	e to the cause of	of death?
Records,	w requires that been signed b should be deta	pa p	Gongrene	log							1 🗆	Yes 2	□No 3□	Probably 4	⊉ Únknown
000	aw re	piet	Severe Pere	phenal 1	rasc	ulas	dize	10 10			24a. Was		24b. Were	autopsy findin	gs available
ž	The faw	Completed by	Atrical Fi	Drilloh	nia						auto perfo 1 ☐ Yes	rmed?	death		r cause or
ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	17.11.0	UV/				26. Place	of Death	(Check only				
Division of Vital	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No		-	ER/Outpatien				rsing Hor	me 5□Resi	dence	6 □Other (S	(pecify)	
Ē	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injur	y occurred		
Sio	Attendia death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not b		***		М		/es 2 □ I		70(1				
\leq	after of Direction by	ertification:	4 Homicide determined		. (Specif	ome, farm, str (y)	eet, factory	, office			City or To			Rural Route N	umber,
	Hospitel or Attending I 24 hours after death. Funerel Director: After tely filled in by the funer	O	29a. Certifier 1 Certifying Ph	ysician: To the best	of my kno	wledge death	3 occurred :	at the tim	no date an	d place is	and due to the	Called(e)	and manna	as stated	
	s Hos 24 h e Fur letely	Medicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examina	ition and/or inv	estigation,	in my op	pinion, dea	th occurr	ed at the time,	date and	place, and	due to the caus	e(s)
	To the Hospitel or Attending Physicien: The I within 24 Hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier				29c		number			29d. Da	e signed (M	onth, Day, Year)
/	/		Ceyor	C.	Ju-	runa	5	D.	506	553		10	5. 2	3-20	300
Y)		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,	Print)	10	n. C		LINAY	101			
	\forall_{Λ}					chron		d.	D	eal		1.D.	20	751	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7	32. Registra	ers Signa	iture	hade	9							

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shoe co 18. Mother's Name (First, Middle, Maiden Surname)

POB 18, Middletown, MD 21769

Reg. No.

2008

4c. County of Death

10g. Citizen of What Country?

USA

14. Bace - American Indian.

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Washington

9. Birthplace (State or Foreign

615PM

10d. Inside City Limits

1X Yes 2 No

Daniel Ralph Kepler Ruth Schildknecht 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebeckah McLaren (Sister-in-law)710 Midway Rd., Frederick, MD 21702

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State XXBurtal Lutheran cemetery 10/21/2008 Middletown, MD 5 Other (Specify) 4 🗆 Donat Donald B. Thompson Funeral Home

Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Due to (or as consequence of):

Due to (or as a consequence of):

Coronary

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23h. Was decedent pregnant

1 ☐ Yes 2 ☐ No 9 Unknown

in the past 12 months?

IF FEMALE:

23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy

5 Other (specify)

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DISCAS

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown

23d, Date of delivery

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury 28b. Time of 27. Manner-of Death (Month, Day Year) 1 Natural

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

0060396

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNSHED

State

Registrar

within 24 hours at To the Funeral D

FARIO 31. Date filed (Month, Day, Year)

32. Registrar's Signature



DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, eatherman

the death certificate be executed attending physician for use as the buria by page 2 s certificate this To the Funeral Director; After completely filled in by the funera the Hospital or Attending hin 24 hours after death.

permit. Pages 1 and 2 Department of Health a

Item 2

Important: If it any injury or c once,

Physician

/Medical Examiner

and

Examiner

Physician/Medical

ð

Medical

Completed Be 1 🗀 Yes 2 Certification:

SE No

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

10118108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ELLEN LEWIS MARY October 24, 2008 10:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 28090 Van Tassel Way 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F 214-32-6549 72 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show ant; Ite Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? 38090 Van Tassel Way 21801 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Social Worker Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard B. Wells ဂ Kathryn Harbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Jeffrey Scott Lewis (Son) 29669 Foskey Lane - Delmar, MD 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park 10/29/08 Crisfield, MD 21. Signature of Superal Service Licensed

Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain metastasis **Physician** /Medical Due to (or as a consequence of) Examiner Metastutic breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. Completed by 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2. No death? 1 □ Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

10

State Registrar

Indititle of certifier

MD D0063835

Indicess of person who completed cause of death (Item 23a) (Type, Print) V LADI MIR IO FIRE

SOLISHUV I/ MD 2/804 Salisbur 200

31. Date filed (Month, Day

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Phys /Me Exan Funer Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fre Madical Evantinal must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of Mary		•	of Death		Reg	2 0	08	355	55
an al	1. Decedent's Name <i>(First, Middle, La</i> Jesus Sa	,	Moral	.es			Date of Death Month Oct 22	Day 2008	Year	3. Time of 053 0	Death M
er,	4a. Facility Name (If not institution, given Holy Cross Ho				own, or Location of	Death		4c. County	of Death	1	
	211 03 4332	Sex 7. Age (In) □ M 2	rrs. last birth	rs. If Under Months	Year If Under 24 Days Hours	Min.	Date of Birth (Month, Day, 11/28/	Year)		nplace (State of Intry) Salva	
lor	Usual Residence of Decedent 10a. State 10b. County MD Montgoi		City, Town	or Location Ville						10d. Inside Cit	
al Direc	10e. Street and Number 909 Baltic Ave	enue		10f. Zip	Code 20853		109	g. Citizen of What Country? El Salvador			
Completed by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2\textbf{X} No If Yes, Give Year or Dates:	ı U.S.	1 X Yes _2	ent of Hispanic Origing Cuban, Mexican, No Specify: I Salva			14. Rad	e - Amer ck, White,	ican Indian,	Ī
npletea	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. i	Decedent's Usual Give kind of work life. DO NOT use	Occupation done during most of retired)			6b. Kind of B	usiness/fi	ndustry	
Be	17. Father's Name (First, Middle, Last Juan Sanchez			Homen	18. Mother		First, Middle, Ma	aiden Surnan	n Ho	me	
0	19a. Informant's Name/Relationship (**.		_	Street and Number	or Rural F		City or Town,			
	20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑	Removal from State	b. Place of I	Disposition (Name or other ipal Ce				c. Location Cusc	City or T		
	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	7-/	unit.		Address of Facility D.RINA Columbia	LDI	FUNERA				01
Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leadin 1 to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Failure Due to (or as a consequence of): Bacteremia Due to (or as a consequence of): Malignant Gastric Carcinoma C. Due to (or as a consequence of): Malignant Gastric Carcinoma Due to (or as a consequence of):										
ysicially we	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death	3 ☐ Ectopic pri 5 ☐ Other (spe					te of deliventh		'ear
ed by r.	Part II. Other significant conditions	contributing to death but not	resulting in t	the underlying ca	use given in Part I.			cco use cont		the cause of de	
Completed by							24a. Was an autopsy performe 1 ☐ Yes 2	24b.	death?	opsy findings a ompletion of ca	vailabluse of
pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋No	Hospital: 1 ☐ Inpatient 2	M EDIO				Check only one)				
ation: 10	27. Manner of Death 1 A Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day, Yea.	28b. Ti		C. Injury at Work?	280	5 ☐ Residen	ce 6 ∐Oth	ner <i>(Spec</i> red	ify)	-
Certing	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Sp	ecify)				Location (Stre City or Town,	State)			er,
Medical Certification: To	(Check only 2 Medical Exal	nysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, nination and	/or investigation,	in my opinion, death	l place, and n occurred	at the time, dat	e and place,	and due	to the cause(s)	
4	29b. Signature and title of certifier 29c. License number D 65305 29d. Date signe Oct. 22										
2	30. Name and address of person who Nabila Khan M 31. Date filed (Month, Day, Year)		orest		Rd. Silv	er S	Spring	, Md 2	0910)	
e	OCT 24 20		B. A	bester							

Regis DHMH 17 Rev 1/2001

for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month /O 062 cm 2005 OLLOCK GERTRUNE 2 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death BOWIE PRINCE GEORGES 12319 STONE HAVEN LANE #18 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1/10/1911 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🕽 F NEW YORK 96 223-54-6893 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits BOWIE 1 Yes 2 □ No MARYLAND PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 U.S.A. 12319 STONE HAVEN LANE #18 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🔀 No Specify If Yes Give Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Gerson Kruger Rose Pomper Kruger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12106 RARITAN LANE, BOWIE, MARYLAND BINNIE ALLENTOFF, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State BRITH ACHIM CEM. CORP 10/23/2008 PETERSBURG, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the discount omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) leur /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident Injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie on who completed cause of death (Item 23a) (Type_Print) Name and address of per TE ·Lal UN 🕏 Règistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 19, 2008 Physician Donald P. McGlvnn 1:50P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Prince George's Renaissance Gardens at Riderwood Village 7. Age (In yrs. last birthday) 5. Social Security Number 577-44-3905 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Davs Hours Min. March 29, 1934 Washington, DC 1 XM 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be retiffed at Maryland Prince George's Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3128 Gracefield Road,#602 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Dates: 1954-1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status after 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 X No White þ Specify: Specify: 3 Widowed 4 □ Divorced within 72 hours Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Iby Ma Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contractor Control Wiring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas McGlynn Catherine McCann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12013 Gordon Avenue Beltsville, Maryland 20705 Dennis W. McGlynn -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/23/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonard V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licenses PA Maryland 20**7**05 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7/41. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of) physician at the burial Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2□No detached 9 Unknown signed by the detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy performed 2 **N**o 1 □Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred al or Attending F Certification: 5 Pending investigation 1 Natural 1 🗆 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

Andrew Kundrat,

31. Date filed (Month, Day, Year) OGT 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

M.D.

2008

Baltimore, Maryland 21215-0036

M. Glynn 3/29/

P.O. Box 68760.

Division of Vital Records,

Goods

10036716

3110 Gracefield Road Silver Spring, Maryland 20904

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 1405 Malcolm McCardell October 23.2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 220-10-5567 92 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 18918 Dover Drive U.S.A. Items 23a 21742 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Itam 27 ie marked other then "natural", or Ite: 1X Yes 2 ☐ No If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Power Company 3 President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adrian LeRov McCardell Fleanor Clingan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. McCardell Wife 18918 Dover Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ita
any injury or ot 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory 10-24-08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²², Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, R. hoel prace 21740 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) er tensive Physician JOVASC Δ /Medical Due of (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (of as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed ementua and physician a s the burial-1 Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Sunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 20 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural within 24 hours efter death. To the Funeral Director: A investigation М 1 | Yes 2 | No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide Hospital recritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 23/200 DS 2323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-10+1 Khalid M. Waseem M.D. 1126 Opal Court, Hagerstown, Maryland 21742 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	ryland /	•	icate of l		Re	eg. No. 2 1 1 3	3555
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	mine	er	4a. Facility Name (If not institution, give s 2603 CHESTNUT GROVE	treet and number)		41	o. City, Town, or	Location of Death		4c. County of Dea	th HINGTON
Fune Direc			5. Social Security Number 6. Sex 1464-62-3743	7. Age M 2□F	(In yrs. last b		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV. 4,	Year) 9. Bir C. 1942 T	thplace <i>(State or Foreign</i> ountry) 'EXAS
Maryland a-f show	med at		Usual Residence of Decedent 10a. State 10b. County MARYLAND WASHING	GTON	10c. City, Tov	vn or Locati		ARPSBURG			10d. Inside City Limits 1 ☐ Yes 2 No
ath with the	iust be not	ਙ∣	10e. Street and Number 2603 CHESTNUT GROV				10f. Zip Code	21782		0g. Citizen of What C U.	S.A.
urs after de	x miner n	by Fur	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:			S Decedent of Hes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	Black, Whi	
be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural" or items 23a or 28a-f show	e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-		(Give kin life. DO	NOT use retired	during most of work 1)	ing	16b. Kind of Business	/Industry
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permit. Page Department of Important: If	any injury once.		21. Signature of Funeyey Service License	ee ,		22. N	ame and Addre	ss of Facility Bas	t-Stauff	er Funera	l Home, P.A.
Physic /Medi			23a. i. n. n. Etery e dis ase, or complishock, ber it failure. Ist only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on ach lin	oh C	are	he mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between onset and Death
icate be executed was physician and	iner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	,	consequence	e of):					
attending	for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 ☐ Fetal dea		etopic pregnanc ther (specify)	у	- oiltea	23d. Date of do	elivery Day Year
quires that the de	90	<u>م</u>	Part II. Other significant conditions con	ntributing to death bu	t not resulting	in the unde	erlying cause giv	en in Part I.	23e. Did tot		to the cause of death?
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pital or Attend	filled in by		4 ☐ Homicide determined	28e. Place of injubulding, etc	. (Specify)			me date and place	City or Town		
the the	npletely	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination a	and/or inves	stigation, in my	opinion, death occu	rred at the time, o	late and place, and de	ue to the cause(s)
To	jo co	2	29b. Signature and title of certifier Dilance	L M	b		29c. Licens	61		19d. Date signed (Mod	
54-20	>		30. Name and addless of person who co	ompleted cause of de	10 NI) (Type, Pri	AVG	Bro	insw!G	10/24/ L,MD	21716
Re	Sta	_	31. Date filed (Month, Day, Year) OCT 2 7 200	100	ar's Signature	Mar	a the a			(

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Irene Sophia McClay 23 October | 2:00 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing & Rehab Center Berlin Worcester Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Months Days Hours 1 🗆 M 86 065-12-7343 March 23, 1922 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director MD Worcester Berlin 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1 Meadow St. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nr any injury or other traumatic event, the Medit once. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Representative <u>Telephone Co</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adam Grodczizki <u>Julia Kurpiewski</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Ann Ruscigno/Daughter 349 Ocean Parkway, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem 10/24/2008 Frankford, DE 21. Signature of Funer 22. Name and Address of Facility Burbage Funeral Home Leali 108 William St. Berlin, MD 21811 23a f art1. Enter the dise shock, or hear fail re e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) EMENT Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed OBSTRUCTIVE PULLWARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? 1 □ Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 death certificate be P.O. Division or Vital Records,

attending physician cate has been signed by page 2 should be detacl funeral director, After this To the Hospital or Attendia within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Funeral

Director

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ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be injury or other traumatic.

Physician /Medical

Examiner

burial-tran

the as

Baltimore, Maryland 21215-0036

McClay, Irene

BA 8

State Registrar

(HIMMARAY) 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

614 B

and manner stated.

29c. License number

🕪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN SHORE UL, SACISBURY MD 2/804

32. Registrar's Signature

			State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and rtificate of Death	d Mental Hygien Reg. N	000000000000000000000000000000000000000
	Physicia	an.	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
J. Dana	/Medic	al	Elsie Elizabeth Murray 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	10/23/200	08 4:30 P M
	Examin		Atlantic General Hospital	Berlin		orcester
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 F		Birthplace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Literature	ocation		10d. Inside City Limits
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	or 28a	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	ath wi		6101 Steve Street	21804	US	
21215-0036	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☐ No Specify:	(Specify Yes of No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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Balt	permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other I	u j	Him William 1	22. Name and Address of Facility 108 Williams St.	Burbage Fune Berlin. MD	
ts.			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as card	diac or respiratory arrest,	Approximate Interval Between Onset and Death
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
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Murra 12/2 I Record	sician: The law s certificate has l irector, page 2 s	Completed	Hypertension		— autopsy performed?	
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Elsie Base - B	Atten er deat ector: by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitely filled in by the funeral director, tely filled in by the funeral director.					
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V)	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
			Jason Synnala Do	1+64428	10	123/2008
	BA6		30. Name and address of person who completed cause of death (Item 23a) (Type Tasan Szymala DD) Atlantic Fenera	111 -11 00	33 Hon-Harry	price Berlin MD21811
	Sta	te	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	1	O 2 Hearmony	to the state of th
	Registr	ar	OCT 2 4 2008 Bleeve &	porter .		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\mathsf{Day}}{24}$, **Physician** 2008 October 2:00 a M Marshall Judith Eleanor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 24664 Paradise Lane Hollywood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F Days Hours Feb. 147-32-8515 66 Director New Jersey Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. Inside City Limits 10a, State show traumatic event, the Mudical Examiner must be notified at Director 1 ☐ Yes 2√ No St. Mary's Maryland Hollywood 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 23a 24664 Paradise Lane 20636 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Hem 27 Is marked other than "natural" or items; any Injury or other traumatic event 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: Specify: White <u>Ş</u> 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dental Assistant Dental Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William ం Rott Ruth Johnston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24664 Paradise Lane, Hollywood, Maryland 20636 Brian Marshall/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) John's Cemetery 10/27/2008 Hollywood, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): burial-P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse i 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 Hospital or Attending Physician: The certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ို this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. 124 hours after death.

e Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical pletely (Check only one) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2

OCT

For State Registrar

E11a

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

Chesapeake Shores

5. Social Security Number

Usual Residence of Decedent

213-42-5101

Elizabeth

4a. Facility Name (If not institution, give street and number)

10b. County

6. Sex

1 □ M 2 🕅 F

28a-f show traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Directo Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, If a Paristin interinged once. 21785 Point Lookout Road 20650 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify Specify: White 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bennett Clara Finley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte Marie Ellis / Daughter 21785 Point Lookout Road, Leonardtown, MD. 20650 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 10/30/2008 Great Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road Leonardtown, Maryland 20650 M01206 ▶ Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Inset and Death Immediate Cause (Final **Physician** eumo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral circlor, page 2 should be detached for use as the burlai-transit completely filled in by the funeral circlor, page 2 should be detached for use as the burlai-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 29 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10-28-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 1890 LaPlata, Maryland 20646 Amir N. Alikhan, M.D. strar's Signature 31. Date filed (Month State 9 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

McCoy

7. Age (In vrs. last birthday)

10c. City, Town or Location

97

Certificate of Death

Months Days

4b. City, Town, or Location of Death Lexington Park

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

2. Date of Death

8. Date of Birth (Month, Day, Year)

01/04/1911

October

2008

4c. County of Death

St. Mary's

6:00

Birthplace (State or Foreign Country)

10d. Inside City Limits

Year

West Virginia

AM

27,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year James Arthur Miller Jr. 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death OASTAL BICE AT ALISBURY COMICO THE LAKE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours Min. 1X M 2□ F 218-48-6845 60 8/18/1948 Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27160 Patriot Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) civil engineer Wicomico County Roads 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Arthur Miller, Sr. Alma Grace Hadnott 19a. Informant's Name/Relationship (Type. Print) Carolyn M. Miller/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27160 Patriot Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Salisbury Crematory 10/23/08 Salisbury, MD Signature of Funeral Service Licensee 22 HOTIOWAYS FURTERAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MBTASTATIC LympHouseof disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 25110 3 Probably 4 Unknown

Physician /Medical Examiner

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Department of Health a Important: If item 27 is any Injury or other tra once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or items 23a

is marked other than "natural"

Director

Funeral

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Completed

Be

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with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

and Mental

21215-0036

Baltimore, Maryland

Examiner Physician/Medical

physician and s the burial-trans attending p s been signed by should be detact certificate has b funeral by the

9

Completed

Be

Hospital or Attending Physician: Certification: To after death Medical State Registrar

this

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No. 9 Unknown

25. Was case referred to medical examiner?

5 Pending

investigation

determined

6 Could not be

1 | Yes 2 | ₩6

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

24a. Was an autopsy

2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Softher (Specify) Ht & plcit

28d. Describe how injury occurred 1 ☐ Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury

(Month, Day, Year)

WAR a Huspyn ASTOC

31. Date filed (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			1 - For amend #5 1	Per FH G8	of Maryla 85 II/2	nd/68epi 26/08Ce	rtment of I	Health and <i>Death</i>	Mental Hy	giene Reg. No.	2000	0== 0
			Decedent's Name (First, Middle				timodio oi		2. Date of De	ath	- 0 0 0	3. Time of Death
	Physicia		Lois Magren Norton						Month	210	2008	8:20 PM
Mark.	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location of Dea	ath	- 35	County of Death	
A.			Washington County H	lospital			Hagerstown	n		Was	shington	
	Funeral		5. Social Security Number 210–22–4876	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yi	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Mir		th ly, Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent			79 Yrs.			August 3	1, 1929	Scran	ton, PA
	show		10a. State 10b. County		10c.	City, Town or Lo	cation				1	Od. Inside City Limits
	Mary P-f sh	tor	MD Washin	gton	H	agerstown						1 ☐ Yes 2 📉 No
	th the or 28; grot	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	th with with with with with with with wi		11105 Glenside Aven	ue				21740		U.S.	Α.	
	tems terms	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of his Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	1	 Race - Americ Black, White, 	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes G			1 □Yes 2 및 No	Specify:		5	Specify:	171.14 -
9	thour	ed	15. Deceden		Dates	16a. Dece	dent's Usual Occu	pation	- 0	16b. Kind	v d of Business/In	Vhite dustry
212	an "na	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed) (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of we	orking			
2	d with	Completed	12	Ooliege	(1 401 31)	Hor	nemaker				Personal Re	esidence
Maryland 21215-0036	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle,	Last)					ame (First, Middle,	, Maiden S	Surname)	
<u>\S</u>	2 should and Men is marke	ပ္	Olen F. Stone					Eleanor Yo				
a N	12 sho		19a. Informant's Name/Relations				ng Address (Street				,	ŕ
တ်	1 and 2 Health em 27 l		Thomas K. Norton III S	oon	20b		2 Pickett Cour		Willian		MD ation - City or To	21795 own, State
no	Pages nent of I unt: If its ury or o		1 🛭 Burial 2 ☐ Cremation		1 State		sition (Name of matory or other pla					
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		I A		Ils Cemetery 2. Name and Addre		31/2008	Clark	s Summit, P	ennsylvania
ä	Imp Dep		Munto	1	1/1/		Douglas A. Fie	ry Funeral Hor	ne, 1331 Easter	m Blvd.,	Hagerstown,	Maryland 21742
130	Physician [®]		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the de each line.			-				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a cons	equence of):	./!					I pour .
L	Examiner	<u>.</u>	Sequentially list conditions,	b. — Due to	o (or as a cons	oguenee of):						
	nsit	mine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	(or as a corrs	equence on.					2.5	
Ć,	exectin and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to	(or as a cons	equence of):						
8760,	ficate be executed physician and s the burial-transit	dical		d								
9	ng ph	Med	IF FEMALE:	_						1		
O. Box	uires that the death certific signed by the attending p d be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	utcome of preg e birth 2□ Fe gnant at time o nown	etal death 3[☐ Ectopic pregnand ☐ Other (specify) _	су		2:	3d. Date of deliv Month	ery Day Year
٠ <u>,</u>	s that ined b e deta	by Pt	Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	tobacco us	se contribute to t	he cause of death?
ğ	w require been sign should by	ed b					<u>-</u>		10	Yes 2□]No 3☐ Pro	bably 41 Unknown
Il Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed							24a. Was auto perfo 1 ☐ Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
Division of Vital	ician; sertifii ector,	Be (25. Was case referred to medica examiner?				15		eath (Check only o			
of	Phys this al dir	۲:	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatie	IL SLIDOA		Home 5 ☐ Resi			fy)
O	ding Ph h. After th funeral	tion	1 Natural 5 ☐ Pendin	g (Mo	nth, Day, Year,	28b. Time of Injury	Wor	ryat ′k?]Yes 2.∐No	28d. Describe	now injury	occurred	
S	or Attend after death Director;	fica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At	home, farm, str	eet, factory, office	1163 2 110	28f. Location (Street and	Number or Run	al Route Number,
Š	al or after	Certification: To	4 ☐ Homicide determ	build	ding, etc. (Spe	ecify)			City or To	wn, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifyir 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my k basis of exam nner stated.	knowledge, deat ination and/or in	h occurred at the to	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due t	stated. o the cause(s)
	To the within 2 To the complete	ğ	29b. Signature and title of certifie		/ co A		29c. Licens	se number			e signed (Month,	
			Menger	1 9/80	af		1.	12836.	7	1	0-27-	- 08
U	H-10		30. Name and address of person	who completed cau	use of death (I	tem 23a) (Type, 368	rull &	treel-	Heiger	feru	1770	21740
	Sta Registr		31. Date filed (Month, Day, Year)	9 2008	Registrar's Sig	nature	hode					
			1114 1 49		No. of the last of	-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ď	For State Registrar	State of Maryla	•	artment of H rtificate of L			ene 3.No.º)	25563
	Physicia	n	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	/Medic	al	DANIEL ELMER NE 4a. Facility Name (If not institution, give s	TZ, SR.		4h City Town or	Logation of Dooth	October	22, 2008	0850 M
	Examin	er	WASHINGTON COUNTY	,			Location of Death	N	4c. County of Death WASH	LINGTON
	Funeral		Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, JAN. 29,		place (State or Foreign
la	Director		220-34-0767 Usual Residence of Decedent	6	9 Yrs.			JAN. 29,	1939 M	IARYLAND
	yland now		10a. State 10b. County	10c. C	City, Town or Lo	cation			1	0d. Inside City Limits
	e Mar Ba-f sl	Director	MARYLAND WASH	INGTON			ERSTOWN			1 ☐ Yes 2 X No
	with th	_	10e. Street and Number			10f. Zip Code	17/0	10	g. Citizen of What Cour	
	ms 23	Funeral	19813 MARVIN AVEN	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	1742 ispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
92	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modeal Exhibitor" must be notified at traumatic event, the "Modeal Exhibitor" must be notified at		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐Yes 2 No If Yes, Give		lf Yes, specify Cuba 1 □Yes 2[X] No	in, Mexican, Puerto Specify:	Hican, etc.)	Black, White, Specify:	etc.
Ö	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Occup		11	6b. Kind of Business/In	HTE
215	e. In "na"	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work	ing	ob. Kind of Business/in	addity
2	filed within Hygiene. other than "ent, the Me	Com	10	College (1-40/ 5+)		PAIN				TING
and	lbe filk ntal H ed oth even:	Be	17. Father's Name (First, Middle, Last)	17 ID				e (First, Middle, Ma	, , ,	
Maryland 21215-0036	should be ind Mental imarked o	ပ	CARMIE LUTHER NET 19a. Informant's Name/Relationship (Type)		19b. Mailir	ng Address (Street a		E MORRISO	JIN City or Town, State, Zip	Code)
Š	5 20 2		JOYCE M. NETZ, SP	OUSE	19813	3 MARVIN A	AVENUE, H	[AGERSTOW]	N, MARYLANI	21742
Baltimore,	it. Pages 1 and rtment of Healt rtant: If item 2 rjury or other		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re	20b. emoval from State	Place of Dispo cemetery, crer	sition (Name of matory or other plac			0c. Location - City or To	wn, State
Ē	. Pa tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Junera Service Licens	BC		O CEMETER 2. Name and Addres		7/2008	BOONSBORO	, MARYLAND
Ba	permit Depart Import any Inj once.	l lo	21. Signature of Funeral Service Licens		2		Bas		er Funeral	
			23a. Part : Enjer the disease, or complice shock, or heart factors. List only on	cations that caused he deale sause on line.	ath. Do not ent	ter the mode of dyin	ig, such as cardiac	or respiratory arres	onsboro MI st,	Approximate Interval Between
	Physician		Immediate Cause (Fin II disease or condition	Aculo		ocardia	I wit	oretion	1	Onset and Death
1	/Medical Examiner		resulting in death)	ue (or as a conse			0			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	ecuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events							
60,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
68760	4- m 01	edical	d						-1-	
Box			23b. was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		∃Ectopic pregnanc			23d. Date of deliv	ery
O. B	requires that the death cer een signed by the attendin nould be detached for use	hysician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 Pregnant at time or		Other (specify)	у		Month	Day Year
٦,	that the ed by detack	Д	Part II. Other significant conditions con	itributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Records,	quires than signed I	d by						. 1 ☐ Yes	2 2 N o 3 □ Prol	bably 4 ☐ Unknown
9 0 0		plete						24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
	The ate h	Completed						autopsy perform 1 □ Yes 2	ed? _ death?	
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	lospital:		ot all post Other	nr.	th (Check only one,		
	y Physer this eral diin	7: To	1 ☐ Yes 2 ☑ No	28a. Date of Injury	28b. Time o	f 28c. Injur	y at	ome 5 Resider 28d. Describe hov	nce 6 ☐ Other (Speci v injury occurred	fy)
ion	Attending Fir death. ector: After by the funera	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accidentinvestigation	(Month, Day, Year)	Injury	M 1 🗆	<br Yes 2 ☐ No			
Division of	or Atter fter de directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	e Hospital or Attendi 24 hours after death, e Funeral Director; A letely filled in by the fo		29a. Certifier 1 Certifying Phys	sician: To the best of my k	nowledge, deat	h occurred at the tir	me, date and place	and due to the ca	use(s) and manner as	stated.
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical Examir one)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occur	rred at the time, da	te and place, and due t	o the cause(s)
	To the within 2 To the I	Ĭ	29b. Signature and title of certifier	1 - 1		29c. License	e number	29	d. Date signed (Month,	Day, Year)
				Neen		3)4	~17°7		10/23/2	008
31	1-12		30. Name and address of person who co ABDU WAHER				VE. HAC	ERSTONY	- un g	1742
ı	Sta		31. Date filed (Month, Day, Year) OCT 2 7 20	32. Resistrar's Sign		1		10		
	Registr	a r	181 7. / 70	HO DEC.	F 25	AASTAN II				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Sylvia Frances Norris October 0 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mary's St. Mary's Nursing Center Leonardtown . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, April 7, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months 1916 578-32-7494 92 Minnesota Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show s 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland St. Mary's Avenue 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20609 37469 River Spring Road 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examination Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No þ If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor/Receptionist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Buskovick Leo Wesloski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 6, Avenue, Maryland 20609 Joe Norris / Nephew Department of Hea Important: If item October 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery Bushwood, Maryland / Injury 29, 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licenses P.O. Box 270, Leonardtown, Maryland 20650 suneth 23a. Part I. Enter the disease, or complications II at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner e017 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transi a and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this s after death. completely filled in by the funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the within 2 To the I

State Registrar

29b. Signature and title of certifier

Avani D. Shah, M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 2008

22650 Cedar Lane Court, Leonardtown, Maryland 20650

29c. License number

29d. Date signed (Month, Pay, Year)

10

08-08184 Craig Pritzl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Craig Pritzl		State of Maryland / Department of For State Certificate of	Health and Mental Hygiene <i>Death</i>	Reg. No. 2008 3556
Physiciar	n/	egistrar . Decedent's Name (First, Middle,Last)	2. Date o	of Death 3. Time of Death
Medical Examin		Craig Michael Pritzl	Octob	per 31, 2008 1052 hrs
3	4	la. Facility Name (if not institution, give street and number) Southern Maryland Hospital	b. City, Town, or Location of Death Clinton	Prince George's
Funeral	. ;	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date	of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		397–64–7011 1X M 2 F 53 Yrs	Months Days Hours Min. Jun.	ne 12, 1955 Foreign Country) Wisconsin
	Ĭ	Jsual Residence of Decedent		10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Local		1 XYes 2 No
daryland 28a-f show any <u>d at once.</u>	후	D.C Washington	10f. Zip Code	10g. Citizen of What Country?
e Mar or 28a	Director	4801 Connecticut Avenue, Apt. 110	20008	USA
		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent	s Decedent of Hispanic Origin? (Specify Yes	
death or item	Funeral	1 X Never Married 2 Married 1 Yes 2 X No	es, specify Cuban, Mexican, Puerto Rican, et	
after	BY.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify: 's Usual Occupation (Give kind of work done	Specify: White
hours "natu	ted		ost of working life. DO NOT use retired)	
336 thin 72 than than edical	ompleted		vey Statistician	Federal Government
21215-0036 Mental Hygiene. marked other than every, the Medical	0	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
2121 uld be fi Mental I marked	o Be	Raymond John Pritzl	Address (Street and Number or Rural Rou	Deth McGrath ute Number City or Town, State, Zip Code)
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	۲	İ		
ore, ME ss I and 2 si of Health ar If tiem 27	1	20a, Metrod of Disposition	per place)	Washington, DC 20017 20c. Location - City or Town, State
MOF Pages I nent of I ant: If		1 X Buriai 2 Cremation 3 X Removal from State 1	ss Cemetery Nov. 3	. I Milwankee Wicconcin
Baltimore, MD permit. Pages I and 2 shon Department of Health and Important: If tiem 27 is injury or other traumating		21 Signature of Euneral Service Licensee 4 22.	lame and Address of Facility ancis J. Collins Fur	
E E E	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	0 University Blvd. W	W., Silver Spring, MD 2090
Physician /Medical		failure. List only one cause on each line.		Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	lovascular disease	
		Sequentially list conditions, b	1.00	
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter underlying Cause		
- ii	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
and ecu	膊	X UNPENDED AMENDED 23a,2/,per ME	g885 11/21/08 TT	
O, be es	edical			23d. Date of delivery
Box 6876C e death certificate the attending physed for use as the b	Physician/M	nast 12 months?	etal death 3 Ectopic pregnancy	Month Day Year
OX 6 ath ce	sicis	1 Yes 2 No 9 Unknown 9 Unknown	ther (Specify)	- 1
cords, P.O. Boy law requires that the deatt has been signed by the att 2 should be detached for	P _J	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 236	e. Did tobacco use contribute to the cause of death?
P.O. es that the signed by be detac	d b		1	Yes 2 ✓ No 3 Probably 4 Unknown
rds, requir	Completed		24	a. Was an 24b. Were autopsy findings available prior to completion of cause of
Reco The law cate has	duc		1	performed? death? Yes 2 No 1 Yes 2 No
Vital Rec ysician: The his certificate director, page	o l	25. Was case referred to medical	26.Place of Death (Check only one	
Division of Vital Records, tal or attending Physician: The law requirers after death. "I Director: After this certificate has been siled in by the funeral director, page 2 should I	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie		escribe how injury occurred
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isio Atten r deat rector by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, str		cation (Street and Number or Rural Route Number, City
Divi	Certification: T	3 Suicide 6 Could not be determined (Specify)	or	Town, State)
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occ	rred at the time, date and place, and due to	the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 6876i To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.		29d. Date signed (Month, Day, Year)
	S	29b. Signature and title of certifier	29c. License number O.C.M.E.	November 1, 2008
416		caulty (O.O.IVI.L.	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21201	
St	ate	31. Date filed (Month, Day, Year) 3 Registrar's Signature	M.	
Regist		NOV 0 4 2008 Bour & God		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Proctor OCTOBER 20, 2008 Marv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLATA CIVISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 18 / 1924 Social Security Number . Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 T F Days 84 579-42-9762 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Nedical Examination and the critifical angre. Director Waldorf Charles Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9711 Hoppy Place 20603 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth John Proctor Alexander ပ PROCTOR, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9711 Hoppy Place Waldorf, Maryland 20603 Darlene Proctor/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pomfret, Maryland 10/27/08 4 Donation 5 Dother (Specify) 21. Signature | First all rvice Licensee St.Joseph 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

coesses

Due to (or as a consequence of):

Due to (or as a consequence of)

Physician /Medical **Examiner**

burial-trar the as use

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Hospital or Attending Physician:

e Funerail

To the within 2

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

and attending physician cate has been signed by the page 2 should be detached completely filled in by the funeral director, after death.

I Director: After t

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death ☐Yes 2☐No

Hospital:

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Year

4 Unknown

Day

3. Time of Death

9. Birthplace (State or Foreign Country) Maryland

Proctor

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 Yes 2 No

CHARLES

14. Race - American Indian,

Black, White, etc.

Specify: Black

USA

5:52 PM

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an performed'

23d. Date of delivery

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Death Natural 5 ☐ Pending investigation 2 Accident

6 ☐ Could not be 3 Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deathy(liem 23a) (Type, Print)

OF CONINS P. SEIN, 3460,000 Washington Road, Such 203A, Would or 32. R gistrar's Signatur

State Registrar

		-	For State Registrar	State of Marylar	•	rtificate of l		Reg	0000	35567
	Physicia		1. Decedent's Name (First, Middle, Las	T.		Park	er	2. Date of Death	Pay Year	3. Time of Death
	/Medic Examin		Alice 4a. Facility Name (If not institution, give	e street and number)	0 1 .	4b. City, Town, or	Location of Death	,	4c. County of Death	
ne d	F		TenINSULQ ROGISMS 5. Social Security Number 6. S		last birthday)	If Under 1 Year	54/15 64/19 If Under 24 H/s.	8. Date of Birth	Wice of 9. Birth	place (State or Foreign
	Funeral Director		218-20-9361	□ M 2X F 81	Yrs.	Months Days	Hours Min.	(Month, Day, Y 4-14-19)		yland
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation		<u>,</u>		10d. Inside City Limits
	e Mary Ba-fsh	Director	MD Wicomic	o I	Pittsvi				0.5	1 ☐ Yes 2 No
	with the		10e. Street and Number	1		10f. Zip Code) F ()	100	g. Citizen of What Cou USA	ntry?
	death	Funeral	7454 Cemetery Roa 11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	∠10 Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modreal Examinant in must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 ▼ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: Wh	ite
21215-0036	72 hou natura		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing 16	Sb. Kind of Business/Ir	
121	within lene. than"	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		bo NOT use retired tal Clerl			. S. Gover	nment
Z Du	e filed al Hygi I other vent, I	Be Co	17. Father's Name (First, Middle, Last)		1			e (First, Middle, Ma	aiden Surname)	
Baltimore, Maryland	should be and Mental s marked o	인	Charles 19a. Informant's Name/Relationship (Taylor,		Helen	ral Route Number I	K1e City or Town, State, Zi	
Ma	and 2 shealth an n 27 is r		Cynthia P. Hubbar			_			aryland 21	
ore,	jes 1 a t of Hea if item or othe	1 13	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b.		osition (Name of matory or other place		Date 20	Oc. Location - City or T	own, State
<u>H</u>	iit. Pages artment of intentant: If ite njury or o		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Fuperal Service Licer	y) Pit		e Cemeter 2. Name and Addre		25-08 P unds Fune	ittsville,	Maryland
Ba	permit. Departr Importa any inji		Million Heer	2 Blake	7	05 E. Mai	in Street	, Salisbu	ry, Maryla	and 21804
ı			23a. Part 1. Enter the disease, or or shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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o,	tificate be executed of physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as a conse	quence of):					
68760,	icate b physic s the bu	edical		d						
Box (an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		□ Ectopic pregnanc	ev.		23d. Date of deli Month	very Day Year
o.	he deal the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			WOTAT	Day real
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ords	require een sig nould b	ted k								obably 4 Unknown
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ita	Physician: The la r this certificate has ral director, page 2	Be Cc	25. Was case referred to medical examiner?					1 ☐ Yes 2, th (Check only one		2 🗆 No
of V	Physician: r this certific ral director, p	မ	1 Yes 2 No	Hospital: 1 Inpatient 2 [28a. Date of Injury	ER/Outpatie	IN SUIDOA		ome 5 Resider	nce 6 Other (Spec	cify)
ion	nding lath. Ith. Takter Takter Takter	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k?]Yes 2 □No	200, 2000120 110	, injury coodined	
Division of Vital Records,	or Atter fter des director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying P	hysician: To the best of my ki	nowledge, dea	th occurred at the t	ime, date and place	e, and due to the ca	use(s) and manner as	s stated.
	To the Ho within 24 h To the Fur completely	Medical	one)	miner: On the basis of examinand manner stated.	nation and/or i					
	To vitt	2	29b. Signature and title of certifier	101	(A A	29c. Licens	nill_C		d. Date signed (Monti	-1
	854		30 Name and address of person who	completed cause of death (Ite	em 23a) (Type	, Print)	1701		Pet. 22 8	7000
			PAIGE WildMAN	CRN9 100 C	e. CAR	Print)	. Salist	bury		
	Sta Regist		31. Date filed (Month Day, Year)	32 Registrar's Sign	B 1	book				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death October 7:11 P M 22, 2008 Patricia Green Rogers 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 10401 Grosvenor P1. #1618 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/17/1924 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 🖾 F Maryland 169-22-8251 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Rockville 1 ☐ Yes 2 No 10f. Zip Code 20852 10g. Citizen of What Country? 10e. Street and Number 10401 Grosvenor Place #1618 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify. ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Buyer Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winifred Webster ္ရ Alfred Marion Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Rogers Costello/Daughter 10401 Grosvenor Pl. #1618 Rockville, MD 20852 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/2008 Falls CHurch, VA 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 21. Signatur of Fundamental review icensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm Metastatic Renal Cancer disease or condition resulting in death) 4 Years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached

Physician

/Medical

Examiner

Director

Funeral

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. In mortant: If item 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Physician/Medical

<u>۾</u>

Completed

Be

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Certification:

Medical

29a. Certifier

30. Name

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Maryland

after death.

Director: A:
d in by the fu within 24 hours aft To the Funeral Di completely filled in 10

> State Registrar

Beven Locks Rd., 31. Date tilled (Month, Day, Year) 24 OCT 2008

address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D10493

29c. License number

John S. Saia MD

29d. Date signed (Month, Day, Year)

October 23, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:20 aM James B. Rogers 2008 October 20, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health & Rehabilitation Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 ☑ M 2 ☐ F Yrs. Director 217-33-8295 80 March 28, 1928 Liberia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XIYes 2 No Director Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a 13918 Heatherstone Drive 20720 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 0, If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No 2 Specify: Specify: "natural", 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, The M 4 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Boima Rogers Sedia Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yema Rogers Mbayo - Daughter 13918 Heatherstone Drive, Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 11/1/2008 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Senile Debility resulting in death) /Medical Due to (or as a consequence of): Examiner Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinsons 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown s peen si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has rail director, page 2 s autopsy perform 2 X No 1 🗆 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28h Time of 27. Manner of Death 28d. Describe how injury occurred After (Month, Day, Year) 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident s after death I Director: in by the 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 29a. Certifie 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56691 October 22, 2008 30. Name and a diess of person who completed cause of de Unitem 23a) (Type, Print) Ghousia Sultana, M.D., 12107 Heritage Park Circle, Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT

2 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08198 State of Maryland / Department of Health and Mental Hygiene 35570 2008 Constance L. Rutherford Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Month Day November 1, 2008 Physician/ 1300 hrs Medical Examiner Eris Constance Louise Rutherford 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Williamsport 301 Coneflower Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min Months Davs Hours Country) Mary land 1924 Dec. 5. Director 83 M 2XF Yrs 219-14-7548 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 X Yes 2 No Williamsport 28a-f show Maryland | Washington Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number notified at USA 21795 301 Coneflower Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. event, the Medical Examiner must be Armed Forces' Never Married Married Yes 2 X No Specify: White Yes 2 X No specify: Divorced If Yes, Give Year 3 X Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) eemit. Pages I and 2 should be filed within 72 hour epartment of Health and Mental Hygiene.
portant: If item 27 is marked natury or other transment. Completed Elementary/Secondary (0-12) Education Cafeteria Manager 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susan Elise Lemen Be Grove Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fairplay, MD 21733 7919 Fairplay Farms Rd. Susan L. Hose - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 1 X Burial 2 Nov.5,2008 | Hagerstown, Maryland Cedar Lawn Mem. Park Donation 5 Other Specify 22. Name and Address of Facility Osborne Funeral Home, P.A. Service Licensee Williamsport, MD 21795 425 S.Conococheague St. Approximate Interval rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death Medical Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - tran Physician/Medical AMENDED 23a, 27, perME, g886 12/31/08 TT X UNPENDED Hospiral or Attending Physician: The law requires that the death certificate be 23d Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 ✔ No 9 Unknown Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes No Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Residence 6 V Other: Scene examiner? Hospital: 1 Nursing Home 5 DOA Inpatient 2 FR/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 27. Manner of Death After Certification: 1 X Natural Yes 2 No Pending Director: death. Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 2, 2008 O.C.M.E. mes 30. Name and address of person who completed cause of death (Item 23a)

SH-0

31. Date filed (Month (TV, Year) 3 2008

Margarita Korell MD.

e strar's Signature

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 24, 2008 October 3:15 a Lakaula Richardson Everett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 45 Feb. 6, 1963 **Alabama** 271-72-8058 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes XX No Directo Leonardtown Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20650 USA 21084 Rose Bay Street ould be filed within 72 hours after death v Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2K Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 à Specify. **Black** 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Computer Technician Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Willie Matthews Vera Richardson Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 21084 Rose Bay Street, Leonardtown, Maryland 20650 Tracy A. Richardson/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2008 | Bedford, Ohio Evergreen Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 20650 JI. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod- of dying, such as cardia, or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death)) /Medical Due to (or as a sunsequen **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a c Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a Was an cate has bage 2 s autopsy performed? certificate 1 Yes 2 No ours after death.

leral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 @ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

within 24 ho

To the Fune

completely f

State Registrar 29a. Certifier

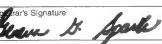
(Check only one)

29b. Signature and title of certif

Medical

Patrick Jarboe Dr. J. 31. Date filed (Month, Day Year) OCT

30. Name and address of person who completed gause of death (Item 23a) Type, Print)



t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Leonardtown, Maryland 20650

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Davs

BETHESDA

Hours

2. Date of Death

Month

OCT

18

8. Date of Birth (Month, Day, Year) DEC . 14, 1932

2008

4c. County of Death

MONTGOMERY

3. Time of Death

10:20 A

10d. Inside City Limits

1 ☐ Yes 2 No

9. Birthplace (State or Foreign

Wash, DC

Certificate of Death

	Mar a-f si	햕	MD Montgo	mery	Rockvi	lle			1 □Yes 2 🔯 No						
	r 28c	Director	10e. Street and Number		10f. Z	ip Code	10g. (Citizen of What Cou	untry?						
	h witl	a	12630 Veirs M	ill Rd, #31	1	20853		U.S.A.							
	y within 72 hours after death with the Mar Jiene. r than "natural", or items 23a or 28a-f st tre Welfort Ever increment be notified	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dece	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White							
9	after or ite		1 ☐ Never Married 2 🔀 Married	1 □Yes 2 No If Yes, Give		2 ☑No Specify:	,	Specify: B1							
8	ours ural",	d by	3 Widowed 4 Divorced	Year or Dates:			404								
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d 2	글 라 그		17. Father's Name (First, Middle, Last)				e (First, Middle, Maid	en Surname)							
lan	o o o	To Be	Melvin S, You	ng		Dorot	thy		-						
Baltimore, Maryland 21215-0036	d 2 sho th and 7 is m traum	-	19a. Informant's Name/Relationship (7 Michael L. Sha		19b. Mailing Addres	eirs Mill Ro	ral Route Number, Cit	y or Town, State, Z Rockvill	(ip Code) 20853 Le , MD						
ē,	ges 1 and 2 nt of Health If item 27 i		20a. Method of Disposition	20b. P	Place of Disposition (Na cemetery, crematory or	ame of	Date 20c.	Location - City or 7	Town, State						
E O	permit. Pages : Department of H Important: If ite any Injury or of		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		Nat'l Cem 1	.0/25/08	Washin	gton,DC						
alti	mit. Dartm Sorta / Inju		21. Signature of Funeral Service Lieun		22. Name 8	and Address of Facility SI	NOWDEN FU	JNERAL F	HOME, P.A.						
ä	permi Depar Impor any Ir		Junge	Junear	246 N	N. Washingto	on St, Roo	kville	, MD 20850						
			23a. Part 1. Enter the disease, or comp	reations that caused the death	n. Do not enter the mo	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between						
J.	Physician		Immediate Cause (Final disease or condition		BSTRUCTIVE	PULMONARY DIS	SEASE		Onset and Death						
	/Medical		resulting in death)												
	Examiner	L	Sequentially list conditions.	b											
	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury											
	and -trans	хаш	that initiated events resulting in death) Last	c Due to (or as a consequ	nence of).										
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68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical		d											
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	death e atte d for u	icia	in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d				Month	Day Year						
P.O.	at the de by the tached	hys	9 Unknown	9 Unknown											
	s tha	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying	cause given in Part I.			the cause of death?						
Vital Records,	w requires t s been signe should be c						1 🗆 Yes	2 X No 3 ☐ Pr	obably 4 Unknown						
၁၁ခ	e law re has be e 2 sho	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of						
ď	The late had page	ĕ					performed 1 □ Yes 2 52	? I death?	2 □ No						
İta	ysiclan: The is certificate h director, page	Be (25. Was case referred to medical examiner?				th (Check only one)								
	Physic r this corral dire	၉	1 ☐ Yes 2 🔯 No		ER/Outpatient 3 🗆 [cify)						
ion of	Attending P r death. ector: After t by the funera		27. Manner of Death 1 [X]Natural 5 ☐ Pending 2 ☐ Accident investigation	1	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	ijury occurred							
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, facto	ory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ural Route Number,						
	Hospita 4 hours Funera ely fille	Medical C	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the caus rred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)						
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	10	m1 2	9c. License number		Date signed (Mont	-						
_			1200	1/600	120	010EE10/A /T	ITI SE	T MET	2000						

01055104A (IN) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State

Registrar

31. Date filed (Month, Day, Year)

MICHAEL R. BAYDARIAN

OCT 24

1 - For State Registrar

10a. State

Physician

/Medical

Examiner

Funeral

Director

MO

1. Decedent's Name (First, Middle, Last)

579-42-9282

5. Social Security Number

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

NATIONAL NAVAL MEDICAL CENTER

6. Sex

GENEVA D. SHAVERS

1 □ M 🕦 F

7. Age (In yrs. last birthday)

10c. City, Town or Location

75

MC

LCDR

legistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-08127 **Donald Simmons**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certif	ficate of	Death		,,,	Reg	. No.	200	0 3337
Physicia ledical Examir	n/	Decedent's Name (First, Middle,La	ast) nald Ralph Simmor	ns, Jr	D		N	ate of Death Ionth ctober 29	Day , 2008	Year	3. Time of Death 2108 hrs
		4a. Facility Name (if not institution, g 106 Bow Street			b. City, Town, o	or Location of	Death		· 4c. Cou Cecil	unty of Death	
Funeral Director			Sex 7. Age (In yrs. last X M 2 F 42	birthday) Yrs.	If Under 1 Ye Months Da		Min.	Date of Birth		Cou	thplace (State or Foreign untry) aryland
any	Ì	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	on						10d. Inside City Limits
ž	to	Maryland Cecil	E1!	kt <u>on</u>				Lio	0	614/1- 1-6	1 X Yes 2 No
utb the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number 463 Booth Stree	+		10f. Zip Code 2192	71		100		of What Cour .ted St	
'S 40 44	neral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of H	lispanic Origin	n? (Specify ⊇uerto Rica	Yes or No- in, etc.)	14. F		ican Indian, Black,
after dez af", or i	by Funer		1 Yes 2 No ed If Yes, Give Year or Dates:		Yes 2 X N				Spec	* *****	ite
2 hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed) 16 College (1-4 or 5+)		s Usual Occup st of working li			done	16b. Kind o	of Business/I	ndustry
5-0036 iled within 72 Hygiene. I other than '	Completed	12 17. Father's Name (First, Middle, La		Labo	rer	19 Mather's	Name (Fire	st, Middle, M		nstruc	ction
21215- ould be filed I Mental Hyg marked oth	Be	Donald Ralph Si	mmons			Bren	da S.	Yate	S		
Baltimore, MD 21215-0003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Medical Programs of the programs of t	은	19a. Informant's Name/Relationship Donald R. Simmo		_	Address (Strooth St				per, City or 219		, Zip Code)
re, N s 1 and 2 f Health if item 2		20a. Method of Disposition 1 Burial 2 X Cremation	20b. Pla		tion (Name of c	emetery,	Novem	ite		ition - City or	Town, State
Baltimore, Permit, Pages 1 and Department of Healt Important: If item injury or other training.	- [4 Donation 5 Other Special	fy: R. A	22 N	s & Co.,	se of Eacility	4, 20				ester, PA
Balt permit. Departu Import injury		23a. Part I. Enter the disease, or cor	1 Hubs	Hi 10	cks Hom 3 W. St	ne for	Funer Stre	als,	P.A. Ikton	, MD	21921
Physician /Medical		failure. List only one cause on	each line.					piratory arres	it, shock, c	or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	LIIGHOI	Incoal	cacion					
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			11					
sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):								
execut an and al - tra	=	X UNPENDED	dAMENDED 23a,27,28	 Ba-f pe	er me g	885 11	-10-0	8 vt			
3760, ficate be g physici s the buri	/Medica	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnat		al death	B Ectopic	pregnancy		23d. Da Mor	ate of delivery	y Day Year
Box 68's death certiff	Physician	past 12 months? 1 Yes 2 No 9 Unkno	4 Pregnant at time of death	=	ner (Specify)		prognancy				1
P.O. Bost that the degreed by the		Part II. Other significant condition	9 Ulkilowii	ulting in the u	nderlying cause	e given in Par	t I.			-	the cause of death?
rds, P.O. requires that the been signed by thould be detach	ted by						N	1 Yes			bably 4 Unknown utopsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been is meral director, page 2 should I	Completed	<u></u>						autops perforr 1 ✓ Yes 2	y ned?		completion of cause of
Vital Rec ysician: The his certificate director, page	Be Co	25. Was case referred to medical examiner?			26.Pla	ce of Death (Check only	L			
F Vit	To	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ✓ El 28a. Date of Injury 2	R/Outpatient		Other ₄	Nursing Ho	ome 5 f	Residence		r:
C # _ ^ #]	ation:	1 Natural 5 Pending 2 Accident Investig	(Month, Day, Year)	3:30pm		Yes 2x		unknov		Codifica	
Division pital or Attendin ours after death eral Director: A	Certification:	3 Suicide 6 X Could n	ot be 28e. Place of Injury - At hom		t, factory, office	e building, etc	. 28f	Location (Some Town, St. 1kton.	reet and Nate) 42	lumber or Ru 1 Wes 1	ural Route Number, City Fulaski Highway
the Hospi hin 24 hou the Funer	Medical Ce	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	, death occur	red at the time, on, in my opini	date and place on, death occ	ce, and due	to the cause	e(s) and ma	anner as stat	ted.
To with To Com	Me	29b. Signature and title of certifier	• Old House			nse number				e signed <i>(M</i> o er 30, 200	onth, Day,Year)
			no completed cause of death (Item 23 tant Medical Examiner 11		treet, Baltin	nore, MD 2	21201				
St Regist		31. Date filed (Month, Day, Year)	32. Régistrar's Signature	Sos	Ke)						
	_		0/	-					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35574 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Margaret Schroeder 10 2008 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth 1 (Magth Day) 1 (923) 7 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Days 1 □ M 2**K** F Pennsylvania 71 196-26-8275 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State N.C 1 Yes 2 □ No Graham Alamance 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 27353 2320 Greensboro/Chapel Hill RD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married White 1 □Yes 2 No Specify Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean McGraw Harry MacDougall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07823 19a. Informant's Name/Relationship (Type. Print) Ronald Schroeder/Son 316 6th Street 20b. Place of Disposition (Name of cemetery, crematory of other place)
George Washington 10/25/2008
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Paramus, N.J. 4 ☐ Donation 5 ☐ Other (Specify) PHILEPPADESRINALDI FUNERAL SERVICE P.A. ral Service Licensee 9241 Columbia Blvd.Silver Spring,Md20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Year of death? ☐ Unknown ngs available of cause of

Physician /Medical **Examiner** Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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d other than "natural", or items 23a or 28a-f show event, the Medical Examiner roust be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Health and Mental Hygiene. em 27 is marked other than other traumatic event, The Ma

Department of Health Important: If item 27 any injury or other trong once.

Saltimore, Maryland 21215-0036

/Medical

burial-trai attending physician for use as the buria cate has been signed by page 2 should be detacl I hours after death. uneral Director: Aft aly filled in by the fur

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): b. Cue to (or as a consequence of): C. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Yea
Part II, Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat 1 ☑ Yes 2 □ No 3 □ Probably 4 □ Unk
		24a. Was an autopsy performed? 1 \(\rightarrow \text{res} \) 2 \(\lightarrow \text{No} \) 24b. Were autopsy findings ava prior to completion of caus death? 1 \(\rightarrow \text{res} \) 2 \(\rightarrow \text{No} \)
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 pripatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ↑ Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	3d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number City or Town, State)
29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) OCT 24

SABYASACH

29b. Signature and title of certifier

(Check only



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number D0063703

TAKOMA PAK

29d. Date signed (Month, Day, Year)

10/22/08

thin 24 hours a

within 24 hor To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Oct 2002 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Center versity Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Sept. 8, 1924 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🂢 F 84 Months Hours De laware 221-16-7377 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 ☐ No Director Maryland Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12756 Scaggsville Road 20777 United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. once. Secretary Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Wiederkehr Pauline Traeger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Wuerstlin -son 9421 N. Laurel Road Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place)

Grace UCC Cemetery 10/26/2008 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Taneytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonard V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Learned 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 48hr **Physician** ntracevehren disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a conse Hience of cause. Enter Underlying Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No o 9 🗌 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 □ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate h perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifi 5

State Registrar

10

e and address of person who

OCT

24

2008

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

mpleted cause of death (Item 23a) (Type, Print)

MI

* Kg

Medical Examiner Marter October	23, 2008 23. Time of Death 23, 2008 12:15 and Co. County of Death Prince George's
As Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution) 4c. Facility Name (If not i	c. County of Death
Renaissance Gardens at Riderwood Village Silver Spring 5. Social Security Number 215-46-2021 1 M 2 F 86 Yrs. 86 Yrs. Social Security Number 1 M 2 F 86 Yrs. Social Security Number 1 M 2 Months	Prince George's
Director 215-46-2021 1 M 2 F 86 Yrs. Months Days Hours Min. Feb. 26, 1	
Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	9. Birthplace (State or Foreign Country) Montana
E 4M L	10d. Inside City Limit
Maryland Prince George's Silver Spring 10g. C	1 ☐ Yes 24CTxN
10g. C 10g. Street and Number 10f. Zip Code 10g. C 20904	Citizen of What Country?
3122 Gracefield Road, Apt. 513 20904 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 N	14. Race - American Indian,
to o E	Black, White, etc. Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/Industry
The state of the s	Medical
De Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide)	
Aaron Sampson Della Todd	
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City	
Carolyn Hendrickson/Daughter 905 Osage Lane, West Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c.	Location - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. 20c	,
Star Widowed Divorced Year or Dates: WWII 15. Decedent's Education 16b. (Specify only highest grade completed) 16b. (Give kind of work done during most of working life. DO NOT use retired) 16b. (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide are not provided by the part of	xandria, Virginia
Solution Funeral Ho 500 University Blvd. W., Silv	er Spring, MD 20901
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) (Medical Immediate Cause (Final disease or condition resulting in death) a. Metastatic Non-Small Cell Carcinoma of Lung	3 month
/Medical resulting in death) Due to (or as a consequence of): Examiner	
Sequentially list conditions, If any, heading to immediate Due to (or as a consequence of):	
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
de de control de la control de	
S IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
9 Unknown	Month Day Year
The part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco	o use contribute to the cause of death?
aubis per pe	2 X No 3 Probably 4 Unknow
1 Yes an autopsy performed? 1 Yes 2 2	24b. Were autopsy findings availab
e de	death?
autopromed? 1	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Vanishing Home 5 Residence 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury	
27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury 28b. Time of Injury Work? 1 Accident investigation 28d. Describe how injury Work?	ary occurred
27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury 28d. Describe	and Number or Rural Route Number,
led Display of the Di	
25. Was case referred to medical examiner? 1	
29b. Signature and title of stripler 29d. License number 29d. D	Date signed (Month, Day, Year)
d24093	October 23, 2008
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, MD 3110 Gracefield Road, Silver Spring, MD	20904
	····

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

08-07911

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Jerome W		e, Jr. For State	Sta	ate of M	/laryland	l / Depar <i>Cert</i>	rtment of <i>ificate of</i>	Health Death	n and	Mental	ı нудіе		. N o.	20	n s	3557
Physician	R	e gistrar . Decedent's Name	(First, Middl	e,Last)							2. Da	te of Death		Year	3. Time of	
Medical Examine	-				White,	Jr.						tober 21			0217	hrs
()	4	a. Facility Name (if	not institutio	n, give stree	et and numbe					ocation of D	Death.			nty of Deat e Georg		
		Prince Geor						If Unde		If Under 2	AHre 8 F	ate of Birth		•	rthplace (Sta	ate or
Funeral	5	. Social Security N		6. Sex		Age (In yrs. la		Months		Hours	16-	-25-1		Fore	ign ountry) M	
Director		218 04		1 XXM	2 F	40	Yrs		<u> </u>			25 1	700			
, and an a		Jsual Residence of 0a. State	10b. County			10c. City,	Town or Local	ion								le City Limits
10 W 3		MD	Pri	ice Ge	eorge	Te	mple H:	ills							1Ye	s XXX X No
iryland	ᅙ	10e. Street and Nur						10f. Zip					g. Citizen c			
he Ma 1 or 28	Director	6712 E	Bershi	e Dri	ve				20748				Jnite	l Sta	tes	
death with the Maryland or items 23a or 28a f show any must be notified at once.		11. Marital Status			Was Decede	ent Ever in U.	S. 13. W	as Decede	nt of Hist	anic Origin Mexican, P	? (Specify Puerto Ricar	Yes or No-		Race - Ame White, etc.	erican Indian	, Black,
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36 iin 72 han "dical	흶	Elementary/Second 12	ondary (0-12)	,	conege (1-4	0.0.7	Carpe	nter					Ca	arpen	ter _	
5-0036 filed within 72 hou Hygiene. fother than "nat the Medical Exa	Completed	17. Father's Name	(First, Middle	, Last)						8. Mother's	Name (Firs	t, Middle, M	laiden Surr	name)	94	
21215 uld be file Mental Hi marked o	<u>a</u>				ite, S	Sr.				Marga	aret l	L. Joi	nes	T C1-	to Zin Cod	2)
imore, MD 21215-C Pages I and 2 should be filed vent of Health and Mental Hygi lant: If item 27 is marked oth or other traumatic event, the	၉	19a. Informant's Na													ate, Zip Code	
MD rd 2 sho ulth and m 27 is	1	George 20a. Method of Dis		te, S	r. (Fa	ther)	D/12 Place of Dispo				ve, 16		20c. Loca	tion - City	20748 or Town, Sta	ate
ore, MCss i and 2 s of Health a of Hiem 27		1 Burial 2	XXCrematic	n 3 🗌 F	Removal from	State	crematory or o	ther place	10-	-26-20	800					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at one.	1	21. Si ture of Fu	inera Servic	e Licensee	me	0/39	/								D 207	
Physician	-	23a Part I. Enter t	he disease, o	or complicati	ions that cau	sed the death	. Do not enter	the mode	of dying,	such as car	rdiac or res	piratory arre	est, shock,	or heart	Approx	kimate Interval en Onset and
Medical	4	failure. List or	nly one caus	e on each li	ne.	ınds (2) of							000		3.0	Death
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, P.O. Box 68760, res that the death certificate be exe signed by the attending physician a be detached for use as the burial	Physician/M	IF FEMALE: 23b. Was deceden past 12 month			Live bir	th	2	etal death	3	Ectopic	pregnancy		Mo	onth	Day	Year
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P.O.	þ	, c. c c c			Ū							1Ye	s 2 🗸 N	lo 3 I	Probably 4	Unknown
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Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been s led in by the funeral director, page 2 should	\vdash	1 Yes 27. Manner of De			28a. Date o	of Injury Day Year)	28b. Time	of Injury		ury at Work	- Isu	d. Describe	how injury	occurred		
on on ath ath the fur	tior	1 Natural		ending vestigation	Oct 21, 2		0126 hrs			Yes 2 🗸	NO					
visi or Att fter de jirect in by	Hica	2 Accident 3 Suicide	6 C	ould not be	28e. Place	of Injury - At	home, farm, s	treet, facto	ry, office	building, et		or Town.	State)			e Number, City
Dir pital ours a curs a	Certification:	4 V Homicide		termined	To the second	Local Str						1 Michelle				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only one)	Certifying	Physician:	: To the best	of my knowle f examination	edge, death oc and/or invest	curred at ti gation, in r	ne time, i ny opinio	date and pla on, death oc	ace, and du curred at th	e to the cat ne time, date	ise(s) and i e and place	e, and due	to the cause	(s)
To th within	Medical	29b. Signature at		ar	nd manner st	ated.				se number					(Month, Day	
	2	Zan. Signature at	افات ان جاری در	1	7	1	>		0.0	.M.E.			Octob	per 21, 2	:008	
		30. Name and ac	L L	on who con	nnleted cause	e of death (Ite	em 23a)		_					_		
487		Zabiullah	Ali, M.D.	Assista	ant Medica	al Examine	er 111 P	enn Stre	eet, Ba	Itimore, I	MD 2120)1				
S	tate	31. Date filed (Mo	onth-Day,Ye	2 3 2	008 32. Re	strar's Sign	ature	1								
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State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:10 PM October 20, 2008 Williams /Medical Carolyn Ann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury eri Year | If Under 24 Hrs. Wicomico 3955 St. Lukes Road Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 1 ☐ M 2 A F 02-25-1941 Pennsylvania Director 67 216-56-1092 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Salisbury MD Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21804 3955 St. Lukes Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗖 No Maryland 21215-0036 Specify Specify. ģ 3 ☐ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Food Service Quality Control Supervisor 10 none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leota Lackey Ray Ashley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16864 Whitesville Road, Delmar, DE 19940 Crystal Massey/daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/2008 Princess Anne, MD 4 Donation 5 ☐ Other (Specify) Beechwood Cemetery 22 Name and Address of Facility Hinman Funeral Home Sinature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) 21/2 YRS ASCVD HISTORY **Physician** LAD /Medical Due to (or as a consequence of): **Examiner** UNCONTROLLED HYPERTENSION UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed HYPERLIPIDEMIA UNIKAGUN and burial-trai Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician UNKNOWN Physician/Medical NIDPM the as esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for Day Year in the past 12 pronths? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2: No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3□ D0A Certification: To this After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division the Hospital or Attending 5 ☐ Pending investigation 1 Natural thin 24 hours after death.

the Funeral Director: A pmpletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 p ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

EB

To the

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifier

1405

14.0

DIVISION

30. Name and ad vess of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

050929

29d. Date signed (Month, Day, Year)

10-22-08

MO 21804 JOY-MADARANG-LEWS, M.D.

and manner stated.

08-08196 Steven Zulauf Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	Certifica	te of	Death				eg. No.	201	18 3558
Physici edical Exami	an/	egistrar . Decedent's Name (First, Middle,Last) Steven Mat	thew ZULAUF			j.	_ I N	Date of Dear Month lovember		Year	3. Time of Death 0936 hrs
		ia. Facility Name (if not institution, give street 11309 Dogwood Drive	and number)	4	b. City, Town, or Lo Hagerstown	cation of	Death			ity of Death	
Funeral Director	l ì	5. Social Security Number 213-78-9487 6. Sex	7. Age (In yrs. last birth	day) Yrs.	If Under 1 Year Months Days	If Under			24,196	Foreid	thplace (State or gn untry) Maryland
nd show any cc.		Usual Residence of Decedent 10a. State 10b. County Maryland Washington	10c. City, Town of Hager		m						10d. Inside City Limits 1 Yes 2 No
he Maryland or 28a-f show	Director	10e. Street and Number 11309 Dogwood Drive			10f. Zip Code 2174	0			10g. Citizen o	S.A.	ntry?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. riked other than "natural", or items 23a or 28a-f sho rent, the Medical Examiner must be notified at once.	Funeral		as Decedent Ever in U.S. med Forces? Yes 2 X No Give Year	If Ye	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, I specify:	Puerto Ric	can, etc.)	Spec	Vhite, etc. ify: wh	
1215-0036 Id be filed within 72 hours after fental Hygierte. narked other than "natural", oven, the Medical Examiner.	mpleted by	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) 12	llege (1-4 or 5+)	during m	t's Usual Occupation ost of working life. In a carrician	on (Give ki DO NOT u	ind of work use retired	k done)		f Business trica	.1 com.
21215-0036 Molta be filed within 72 Mental Hygiene, marked other than e event, the Medical	Be Com	17. Father's Name (First, Middle, Last) Charles C.	Zulauf		1			Barb	Maiden Surn ara Ri	der	
Z = 8 = 5		19a. Informant's Name/Relationship (Type, Pi Barbara Zulauf - mot	her 1	1309	Address (Street Dogwood	Dri	ve, F	lagers	town,	Maryl	and 21/40
		20a. Method of Disposition 1 Burlal 2 XCremation 3 Re 4 Donation 5 Other Specify:	moval from State cremat	ory or ot	n Cremato	ry	Noven 5, 2	800	Hag	ersto	or Town, State
Baltimore permit Pages 1 Department of F Important: If		21. Signature of Funeral Service Licensee Fine L Vestis	/	41	Name and Address 5 East Wi	.1son	Blvc	1., Ha	Funera	wn, M	ne faryland 2174 Approximate Interval
Physiciar Medica tamine	1		is that caused the death. Do not be seen to be seen that caused the death. Do not be seen that caused the death of the death of the death. Do not be seen that caused the death of the d			such as ca	ardiac or re	espiratory a	rrest, snock, t	or near.	Between Onset and Death
	iner	cause. Enter Underlying Cause	(or as a consequence of):						· 		
760, icate be executed physician and	Examiner	events resulting in death) Last	(or as a consequence of):		per,ME	*111115	1177	8/08 7	ידיי		
e exec	Medical	X UNPENDED AMI	ENDED 43a,47,20a	,	per,	3003	227.2	77.23		1 - 6 4-1	
Records, P.O. Box 68760, The law requires that the death certificate be executed crate that been signed by the attending physician and character for the attending physician and the character for the strength of Corners as the burial.	ia E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 1 Yes 2 No 9 Unknown g	Live birth Pregnant at time of death Unknown	2 F	etal death 3 Other (Specify)	Ectopio	c pregnan	су		ate of delive	ery Day Year
P.O. BC	by Physic	Part II. Other significant conditions conti		ng in the	underlying cause (given in Pa	art I.			0 3 P	to the cause of death? robably 4 Unknown
Division of Vital Records, P.O. But to the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the	Completed							pe	as an topsy rformed? s 2 No		
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Division of Vital Division of Vital With Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this Cettle	Tilled in by the fune Certification:	3 Suicide 6 24 Could not be determined	28e. Place of Injury - At home, (Specify) house					Hager	stown,	MD	Rural Route Number, City ogwood Dr.
Fo the Hospital Within 24 hours	completely f	one) 2 Medical Examiner: On and	o the best of my knowledge, d he basis of examination and/or manner stated.	eath occ r investig	ation, in my opinio	n, death o	ccurred at	the time, d	ate and place	, and due to	Tile Cadse(s)
ا چ ≥ چ	Ne Me	Womanie Ine	Shule		29c. Licen O.C	se numbei .M.E.	r			nber 2, 2	Month, Day,Year) 2008
		30. Name and address of person who comp Margarita Korell MD. Assist	leted cause of death (Item 23a ant Medical Examiner	111	Penn Street, E	Baltimor	e, MD 2	21201			
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	, do	book	B					
Rec	gistra	NOV 0_7	LUUU Justinia	W C	The state of the s						

Amend #7 per FH G885 11/12/08 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Registrar	State of Mary Item 26 per	yland ve r	L/ Depa b., go Cer	riment of 135, 11/10/ tificate of	Death	Mental Hy	/gien Reg. N	e 2008	35581
	Physicia		1. Decedent's Name (First, Middle, La Allen J. Bre	ymaier					2. Date of De Month Novembe	D	y 2008	3. Time of Death 1:15 pm M
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o	r Location of Deat	h	4	c. County of Death	1
1			Quail Run Assist	ed Living			Parkville				altimore	
	Funeral Director		213-30-2552	Sex 7. Age (III	In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D	rth a <i>y, Ye</i> a 33	9. Birth Cou Mary	nplace (State or Foreign untry) Land
	and w		Usual Residence of Decedent 10a. State 10b. County	10	0c. City.	Town or Loc	ation					10d. Inside City Limits
	taryla sho	ō	,									1 □Yes 2√⊋No
	the M	ect	Maryland Baltimo 10e. Street and Number	re County	Not	tingha	10f. Zip Code		T	10a. C	Citizen of What Cou	
	with a or	ä	PO. Box 44301				21236				ited Stat	-
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S.	. 13. V	1	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N		14. Race - Amer	
36	জ হ <u>'</u> '	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼□ Divorced	Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates: 19			Yes, specify Cuba	an, Mexican, Puer Specify:	to Rican, etc.)		Black, White	, etc. ite
ŏ	2 hou	Completed	15. Decedent's En	ducation	- 1	16a. Deced	ent's Usual Occup	oation during most of wo. d)		16b.	Kind of Business/la	ndustry
215	hin 7. e. an "n	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		lite. L	OO NOT use retired	d) d)	rking			
213	d witt	Con		4	C	Contra	cts Admi	nistrato			rospace	
P	al Hy d oth	Be (17. Father's Name (First, Middle, Last,					18. Mother's Na				
<u>ya</u>	Ment Ment arked atic e	ဍ	John J. Breymaier	, Jr.					et R. Mi			
<u>a</u>	2 shc and is m		19a. Informant's Name/Relationship (Type. Print)							or Town, State, Z	
2	and lealth m 27 her tu		Anne Breymaier/Da	ughter							Maryland	
o o	t of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	J Remova! from State			sition (Name of natory or other place		Date		Location - City or T	
Ē	tmen tant: jury		4 ☐ Donation 5 ☐ Other (Special	(y)	Bayv		rematory				timore, N	
Baltimore, Maryland 21215-0036	permit Depar Impor any In once.		21. Signature of Funeral Service Licer	lle							eral Home Maryland	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line.	e death.		areas were				+ 1	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	onseque	ne of):	carc	NON	0)	ne	laste	2/20
	Examiner		Conventially list conditions	b	- 0							
	დ ≠	iner	Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a so	onseque	snes ofy:						
	ficate be executed i physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
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× ×			IF FEMALE:	23c. If yes, outcome of p	pregnan	cv					23d. Date of deli	Verv
# 0. Bo	The law requires that the death certiate has been signed by the attending age 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal	death 3 □	Ectopic pregnand Other (s <i>pecify)</i> _	cy .			Month	Day Year
<i>2</i> •••	s that ned b	by P	Part II. Other significant conditions	ontributing to death but n	ot result	ting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
35	quire;	d be							10	Yes	2 No 3 Pro	obably 4 🗌 Unknown
Record	The law re cate has bee page 2 sho	Completed							24a. Was auto perf 1 □ Yes	psy ormed?	prior to c death?	topsy findings available completion of cause of
		Be C	25. Was case referred to medical					26. Place of De	ath (Check only		10 10 103	2 🗆 110
\$5	Physici this cer al direct		examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1 Inpatient	2 🗆 E	R/Outpatien	t 3 ☐ DOA Oth	ner: 4 Nursing I	Home 5 ☐ Res	idence	6 K Other (Spec	Assisted
the spin of	ing f	ion:	27. Marrier of Death 1.3 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye		28b. Time of Injury	28c. Injur Wor	ryat k? Yes 2∐No	28d. Describe	how inj	ury occurred	
Sic	ottend death ctor: y the 1	icat	2 Accident investigation 3 Suicide 6 Could not b	e Diago of Injury	- At hom	ne farm stre		res 2 🗆 NO	28f Location	(Street	and Number or Ru	ral Route Number
É	tal or A s after o al Direct ed in by	Certification: To	4 Homicide determined	building, etc. (S	Specify)	ie, iaiii, sue	est, lactory, office		City or To	wn, Sta	ite)	arriodic Nambol,
:	ne Hospital or Attend n 24 hours after death ne Funeral Director. /	edical		nysician: To the best of m nIner: On the basis of ex and manner stated	camination							
_	To the within 2 To the complete	Me	29b. Signature and title of certifier	2 // 4 .		0 11	29c. Licens	se number		29d. D	Date signed (Month	, Day, Year)
			1//laux	· Call	0	ll	PL	12817	/		11/5/	US
	(8)		30 Name and address of person who	delphi	1	, Ro	1. B	alto.	MO.	2	2123	7
	Sta Registra	_	31. Date filed (Month, Day, Year) NOV 1 0 20	32 Registrar's	Signatu	re	refail					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARGARET ELIZABETH **BROGNA** NOV. 4 2008 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS HEALTHCARE-HAMILTON BALTIMORE 8. Date of Birth (Month, Day, Year)
TTINE 3, 1911 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 1 F 97 216-01-1874 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 337 S. BALLOU COURT 21231 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHRISTOPHER NIEMAN ပ WILHEMINA ECKERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA BROGNA/DAUGHTER 5902 PRESTON OAKS RD, #2092, DALLAS, TX. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 11/8/08 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Control of Control INC. FUNERAL HOME AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sa Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnap 3 ☐ Ectopic pregnancy in the past 12 mon Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an has certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 20 No 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manual of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours atter death To the Funeral Director: filled in by

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

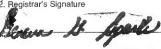
(Check only one)

29b. Signature and title of certifier

mendel 31. Date filed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



8813

and manner stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Worthern Woods Road-

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 11.30 AM November 7,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore TRANKford NURSING Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** North Cosul in A 1□ M 2 F Days 225-46-6396 Months Hours Director Usual Residence of Decedent 10c, City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Director Md 10e. Street and Number 10g. Citizen of What Country? USA 21213 "natural", or items 23a 2007 Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 BLack Specify: 3 ₩Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 52 should be filed within 7 hand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Datky Operator echine permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be L1219 enRi ဂ္ 19a. Informant's Nante/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter atayette 2007 1 Balto. Md, 21213 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mt 2100 Cometery 15/08 4 Donation 5 Dother (Specify) 21. Signature of Peners Service Licens 22. Name and Address of acility 1, 1/ex 3 Mettepolitum chapel Bacto Broadwa 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic /Medical Due to (or as a consequence of) Examiner Copp severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dementia as the burial-trar nding physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a P.O. ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number An D0066508 11/10,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N Entan St Saite 405 - Balt 201201 TaFreshi Mirebrah, mi 32 Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#8perFH, G885, 11/10/08, ws
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician O4 2 ර්රී්පි 2:06a.M Crutch Carlton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Augsburg Lutheran Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 243-28-3145 NC Director 85 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I've Medical Examirer must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 ☐Yes 2 ☐ No Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 U.S.A. 1201 East Northern Pkwy Funeral 12. Was Decedent Ever in U.S. Armed Forces? M☐Yes 2☐No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 <u></u> 1 ☐ Yes 2 No Specify. Black Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Bethlehem Steel 12th gradé 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Suzzie Morris ပ Henry Crutch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 222 Glyndon Drive, Reisterstown, Md 21136 Phyllis Crutch-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Pages 1
Department of F
Important: If Ite
any Injury or ott X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn 11/8/08 Baltimore Co, Md 5 Other (Specify) 4 Donation Sign Ture of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lm1 ediate Cause (Final disease or condition resulting in death) **Physician** Sigmail color y-pavs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and a The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year ed by the a 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate has been signated by page 2 should b 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate performed' spital or Attending Physician: The hours after death, neral Director: After this certificate y filled in by the funeral director, par 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: All Nursing Home 5 TResidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 8005,P Novembe 1 30. Name and address of person who cor oleted ause of death (Item 23a) (Type, Print) Reisterstan MO 21136 Sef 75 Many Zibell egistrar's Signature 31. Date filed (Month, Day, Year) 32.

State

Registrar

NOV 10

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State State Begistrar State 1		30. Name and address of perso	who complet	ed cause of	death (Iten	n 23a) (Type,			-		7 1 10	1000		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u></u>		NOMEN ALEA	4	3	3001	501711	HANG	OVER :	STREET	BALT	MORE	MAR	2172 (HANY)
Hegistrar NAV 1 0 2008 April 10 April 1			31. Date filed (Month, Day, Year)	32. Regist	trar's Signa	ature							
	Regist	rar	NOV 1 (2008	Alex.		the fly	MARI						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Donald Emory Creswell volember 5 2008 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 🕅 M 2 🗆 F 88 220-09-4796 Nov. 21, Director 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show traumatic event, the Wadlest Evar, it we must be notified at Director 1 ☐ Yes 2 X No -28a-f Maryland Baltimore Fullerton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 7436 Brookwood Avenue 21236 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 XYes 2 If Yes, Give 2 🗆 No 1 ☐ Never Married 2 ☐ Married than "natural", or 1 ☐ Yes 2 📉 No Specify: Specify: White \$ 3 M Widowed 4 □ Divorced Year or Dates: 1944-46 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygies 7 is marked other the Years Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Charles Creswell Katherine Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Carroll Creswell - Son 30 Melbourne Way Basking Ridge, NJ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages permit. Pages Department of Important: If It any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem 11/8/08 4 Donation 5 Other (Specify) Overlea, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, 415 Belair Road Baltimore, Home, 23a. Part 1 Enter the bisease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical I guipu 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mucal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ...
autopsy
performed?
Yes 2 No page certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending nours after death.

neral Director: Al

filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00000

To the P

Box 68760.

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Records,

Vital

of

Division

State Registrar

DHMH 17 Rev 1/2001

Franklin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Iroha

DHMH 17 Rev 1/2001

08-08251

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

opert Carr		For State Of Maryland / Department	of Death	Reg.	No.	
Physician		egistrar I. Decedent's Name (First, Middle,Last)		2. Date of Death Month D November 3	ay Year	3. Time of Death 1150 hrs
ledical Examine		Robert Hampton Carr	4b. City, Town, or Location of Death		4c. County of Deat	
	4	ta. Facility Name (if not institution, give street and number) 130 Lubrano Drive Apt. L1	Annapolis		Anne Arunde	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		_	MM/DD/YYYY) 9. B Fore	ian
Director		226-62-9556 1XM 2F 61	Yrs. Months Days Hours Min	Feb. 13	, 1947 ^C	ountry) Virginia
> 2	-	Usual Residence of Decedent 10c. City, Town or I 10a, State 10b, County 10c. City, Town or I	ocation			10d. Inside City Limits
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Maryland 28a-f show datonce.		10e. Street and Number	10f. Zip Code	ľ	. Citizen of What Co	untry?
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h with		A Nove Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 	o Rican, etc.)	White, etc.	encan indian, black,
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urs aft tural'	ੂ⊢	15. Decedent's Education (Specify only highest grade completed) 16a. De-	cedent's Usual Occupation (Give kind of ing most of working life, DO NOT use re		6b. Kind of Busines	
21215-0036 Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	op Mechanic	F.	laryland S Profession	
21215-0036 Montal Hygiene. Marked other than c event, the Medica	<u></u>	17. Father's Name (First, Middle, Last)	•	ne (First, Middle, Ma		
215- e filed tal Hy ked of	e B	William H.M. Carr	Betty			
21 hould the Mer is mar	0	Tod: Information February	Mailing Address (Street and Number or P.O. Box 344 Tappa			1
imore, MD 2 Pages 1 and 2 shou ment of Health and Interest 1 item 27 is not other traumatic	-	20s. Method of Disposition 20b. Place of Disposition	Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
ges 1 at of He	1	1 X Burial 2 Cremation 3 Removal from State Crematory	or other place) Cemetery 11	/7/08	Tappahar	nnock, VA
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: LSSEX 21. Signatury of Funeral Service Licensee	22. Name and Address of Facility Ma	rks-Brist	ow Funera	1 Home
Perm Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep	Ĺ	Jan Dendle	P.O. Box 235			7A 22560 Approximate Interval
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.				Between Onset and
Laminer	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ardiovascular dise ver	ase and I	IDFOSIS (
		Sequentially list conditions.				4
	Ĭġ.	if any, leading to immediate cause. Enter Underlying Cause c.				
E . C/1,	Examiner	events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	曺	X UNPENDED AMENDED 23a,27,per	ME, g885 11/26/08	TT		
60, ate be e hysicia e buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	· ·
687 certifica iding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pred Other (Specify)	gnancy	Month	Day Year
30x death c	Physician/	1 Yes 2 No 9 Unknown g Unknown				t dooth?
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ital sician: is certil	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Ou	I Other I		Residence 6 🗸 C	other: Scene
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the flaneral director, page 2 should be detach.	Certification:	3 Sulcide 6 Could not be determined (Specify)	m, street, factory, office building, etc.	or Town, S		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier	th occurred at the time, date and place,	and due to the caus	se(s) and manner as	stated.
thin 24	Medical	Check only one) 1 Certifying Physician. To the best of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
F ≥ 5 8	Me	29th Signature and title of certifier	29c. License number		November 4,	(Month, Day, Year)
		Willand Ine Gull	O.C.M.E.		14040111061 4,	
ϕ		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	1D 21201		
۳ St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- AA 0			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35589 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month No ven Ser Day Year 10:40 AM COHEN 6 2008 RAYMOND 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Silvai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 07/22/1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) ___ Days 1 X M 2 □ F Months Hours MD 218-12-0344 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No BALTIMORE OWINGS MILLS 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12142 VELVET HILLS DRIVE 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify. WHITE Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER HARDWARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COHEN MARY COHEN **JACOB** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12142 VELVET HILLS DRIVE, OWINGS MILLS, MD GARY COHEN / SON 20b. Place of Disposition (Name of cemetery, Grematory prother place) MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/07/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxia 1 day Due to (or as a consequence of): 4 days Prevnouia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Urenic Osstrictive Polyionay Disease Due to (or as a consequence of) 23d. Date of delivery Month Day Year use contribute to the cause of death? Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 6 ☐ Other (Specify)

s burial-transit the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fi

Physician

/Medical

10a. State

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Director

Funeral

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Completed

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Examiner

Funeral

Director

than "natural", or Items 23a or 28a-f show

is marked other

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimoré, Maryland

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Medical Examiner

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Medical

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Jonathan

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23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat
Lung Ca	ncer	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unki
Congestive	ncer Leart Fadure	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Hom	ne 5 🗆 Residence 6 🗆 Other (Specify)
27. Manner of Death 1	(Month, Day, Year) Injury Work?	8d. Describe how injury occurred
3 □Suicide 6 □Could not be 4 □ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place, a inner: On the basis of examination and/or investigation, in my opinion, death occurre	

12

Registrar

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Sinai Registrar's Signature

Hospital of Balhmore

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

08-08269 Cletus Gittens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	rtificate c	of Dea	th			F	Reg. No.				
Physicia ledical Exami	ın/	1. Decedent's Name (First, Middl Cletus	e,Last)			C	itte	ns		Date of De Month Novembe	Day	Year 08		Time of Death 0014 hrs	
and the second		4a. Facility Name (If not institutio Northwest Hospital	n, give street and num	nber)			Town, or Lo		Death			County of altimore		у	
Funeral Director		5. Social Security Number		7. Age (In yrs.	•	Mon	der 1 Year ths Days	If Under Hours	24Hrs. 8 Min.				Torus	lace (State or For	
ν.	. A .	215-35-4258 Usual Residence of Decedent	1 X M 2 F	25					01	16	83		inadad Od. Inside City Lim		
nd show an	_	10a. State 10b. County	NA		Balti		:				1X Yes 2				
e Maryla or 28a-f	Director	10e. Street and Number	Dood		-	10f. Z	ip Code	244		n	10g. Citizen of What Country?				
with the ms 23a o		1930 Greenga	12. Was Dece			13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Ouban, Mexican, Puerto Rican, etc.)						14. Race - White,		n Indian, Black,	\dashv
fter death	y Funeral		arried 1 Yes orced If Yes, Give Year	2X No		1 Yes 2 X No specify:						Specify:		ck	
hours a "natura"	ted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decede		al Occupatio orking life. D					and of Bus			
0036 Within 72 itene. ner than Medical	Completed	12th grade	2yr		Co	onstruction Worker 18.Mother's Name (First, Mi					1		ruct	ion Co.	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	å	17. Father's Name (First, Middle, Augustine Gi	ittens				Lydi	n R	amse	Y					
Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	5	19a. Informant's Name/Relations Lydin Ramsey					ss (Street								14
more, Pages 1 and not of Healt not Healt not recent or recent not not not not not not not not not n		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fro		Place of Dispo crematory or o	other plac	e)	· 1		Date		ocation -	•		-
Baltim permit: Pag Department Important injury or o		4 Donation 5 Other S 21. Signature of Funeral Service			Wood		n nd Address of n F/h			.0/08	l B	alti	more	e Co, M	a
M & A E E		23a. Part I. Enter the disease, or		used the deat	14	300	Waba	sh A	ve,	Bal lespiratory a	timo rrest, sho	ore, ock, or hea	Md	21215 Approximate Inte	
/Medical xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	Maritimin Com											Between Onset a Death	and
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ox 68 ath certifi attending or use as	Physician/I	23b. Was decedent pregnant in the past 12 months?	he 1 Live bi	irth ant at time of c	2 F	Fetal dea Other (S)		Ectopic	pregnanc	У	8	Month	Da	y Year	I
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tal Records, ctan: The law require certificate has been si ector, page 2 should t	Completed									per 1 🗸 Yes	opsy formed? 2 N	d	eath?	·	
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical 25. Place of Death (Check only one)														
of Vital ling Physician After this certi funeral director	٠. ت	1 ✓ Yes 2 No 27. Manner of Death	, L		28b. Time o		DOA 28c. Injury		2	8d. Describ	e how inju			_	_
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Divis	1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined Coperation of the determined Specify) Parking Lot 1 Natural 5 Pending Investigation 2312 hrs 1 Yes 2 No Subject shot 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot 28f. Location (Street and or Town, State) 7141 Security Bouleva												City		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical (29a. Certifier (Check only one) Certifying P Medical Exa	hysician: To the best aminer:On the basis o and manner st	of examination	dge, death occ and/or investig	curred at sation, in	the time, dat my opinion,	e and plac death occ	ce, and du curred at t	ue to the ca he time, da	use(s) an te and pla	nd manner ace, and d	as stated ue to the	i. cause(s)	
5. ½ ₹. 50. 00. 00. 00. 00. 00. 00. 00. 00. 00	Me	29b. Signature and title of certific		d		2	29c. License O.C.N					Date signe		h, Day, Year)	
3		30. Name and address of person							0405	-			, _ 2 3		
J	ate			Examiner gistrar's Signa	111 Penr	23		re, MD	21201	-					
Regis		4 0	2000	Rose of	IF. A	ALLES.	4								

			For State	State of Maryland	-	artment of F rtificate of			iene	8 (35591
			Registrar 1. Decedent's Name (First, Middle, Last)			imouto or	Douth	2. Date of Death			3. Time of Death
	Physici		Charles A 60					Month i i	Day OU a	Year 2008	6:00 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death		4c. County		
	LXUIIII	-	628 S Grund	y Street		Balti	more		N	I/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vearl	9. Birthpl Count	lace (State or Foreign
	Director		215-52 - 4117	M 2□F 61	Yrs.	Months Days	Hours Will,	JAN. 24	, 1947	COUNT	MD.
	p .		Usual Residence of Decedent 10a. State 10b. County	10a City	Town or Lo	nation				1/	Od. Inside City Limits
	shov	~	MD. N/A		BALTI					10	1X Yes 2 □ No
	Ba-f	ecto	10e, Street and Number					10	Og. Citizen of W	that Cause	
	with t	Ö	628 S. GRUNDY ST.			10f. Zip Code	21224		•		
	ours after death with the Maryland ral', or items 23s or 28s-f show Examiner must be moillfied at	Funeral Director		2. Was Decedent Ever in U.S.	13 \	Was Decedent of H			NITED S	- America	
		Ë	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X No	. 10.1	f Yes, specify Cub	fispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White, e	
2-003p	hours after tural, or ite al Examine	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Specify:	WI	HITE
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7	filed within Hygiene. sther then "	5	10TH	0	A	UTOMOTIV	1		SELF-		OYED
2	uld be filed Aental Hyg rked othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		faiden Surname	9)	
<u>\frac{2}{3}</u>		2	ROBERT GUMP					UNZELMAN			
Maryland	0 a = 0		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, S	State, Zip	Code)
	s 1 and of Health item 27 other tr		MARGARET GUMP/WI 20a. Method of Disposition			S. GRUND	Y ST, BAL		MARYLAN 20c. Location - 6		1224
Baltimore,	it of H		1 ◯XBurial 2 □ Cremation 3 □ Re	emoval from State	netery, crer	natory or other pla	ce)				
	t. Pa rtmer rtant rjury		4 Donation 5 Other (Specify)			ART OF J	ess of Facility CH		ALTIMOR	-	
e n	permit. Pages Department of h important: if ite eny injury or of once.		21. Signature of Funeral Service License	е			ERN AVE.,				
			23a. Part1. Enter the disease or complice shock, or heart failure. bist only on	cations that caused the death.	Do not ent	er the mode of dy	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
3	Pnysician		Immediate Cause (Final disease or condition	ASCVI							Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):						
	Examiner		Sequentially list conditions, b								
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	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						-
58/60	icete be executed physicien and s the burial-transit	alE									
89		edical									
XOR	death certifi e attending id for use as	M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnant					23d. Date	e of delive	ry
	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea]Ectopic pregnanc] Other (specify) _	у		Mon	ith I	Day Year
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_	signed to be det	by	Part II. Other significant conditions con	tributing to death but not result	ting in the u	nderlying cause giv	ven in Part I.				e cause of death?
ecords,	w require been si should I	ted						1 ∐ Ye	s 2 No	3 Proba	ably 4. Unknown
ပ္	The law requires thet the te hes been signed by th age 2 should be detache	Completed						24a. Was an autopsy	24b. W	Vere autop	psy findings available inpletion of cause of
Ī		S						1. Yes 2	ned? d □ No 1	Yes	2 No
VItal	icien: T certificet rector, pa	Be	25. Was case referred to medical examiner	ospital:		1 04	26. Place of Deat	h (Check only one	9)		
0	Phys this	P.	1 Yes 2 No	1 Inpatient 2 E	R/Outpatien 28b. Time of	IL 3LI DOA		me 5 Reside)
5	ding f h. After funer	盲	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 □No	28d. Describe ho	w injuly occurre	,u	
DIVISION	Attendi or deeth. ector: A by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne. farm. str			28f. Location (Str	reet and Numbe	er or Rural	l Route Number.
2	of or Att	Certification;	4 Homicide determined	building, etc. (Specify)				City or Town	, State)		
	To the Hospitel or Attending Physicien: within 24 hours after deeth. To the Funersi Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	ician: To the best of my know	ledge, death	occurred at the ti	me, date and place,	and due to the ca	use(s) and mar	nner as st	ated.
	in 24 in 24 the Fi	Medicai	one)	er: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	opinion, death occuri	red at the time, da	ite and place, a	.na aue to	tne cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed	(Month, L	Day, Year)
			MD			DOC	06++60	٨	11/05	1200	28
	4		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type,	Print)	1	1		212	N-7_
			Jason A Stein 31. Date filed (Month, Day, Year)	2 Registrar's Signatur	KCVN	an Dri	re, 1501	timore,	MD	414	OT
	Sta Registr		NOV 1 0 2008	mpleted cause of death (Item 2	Gene						
			V	6	W						

		1	For State Registrar	state of Ma	aryland	-	rtment <i>tificate</i>			ind M	ental Hygi	ene		35592
			Decedent's Name (First, Middle, Last)								2. Date of Death			3. Time of Death
	Physicia	_	RAYMOND	HAR	ME	_					Month	Day	Year 2008	8:25 AM
The same of the sa	/Medic Examin		4a. Facility Name (If not institution, give stre				4b. City, To	wn, or	Location of	f Death		4c. C	ounty of Death	
			GOOD SAMARITAN				BALT							
	Funeral		5. Social Security Number 6. Sex	7. Ag	(In yrs. las	t birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 9-20-19	Year)	Coui	place (State or Foreign ntry)
	Director	-	220-07-7140 Usual Residence of Decedent		88	110.					9-20-19	20	Md.	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Mary a-f sh	tor	Md. Harfor	đ		Abin	gdon							1 □ Yes 🗶 □ No
	or 28g	Director	10e. Street and Number				10f. Zip C	ode			10	g. Citize	en of What Cou	ntry?
	23a c		131 St. Mary's	Church	Road			1009					USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medical Event, In Intelligent 200ce.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Armed Forces? 1 ★ Yes 2 1 If Yes, Give Year or Dates:		.v '	Was Decede fYes, specify I □Yes 2	y Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	Ì	4. Race - Ameri Black, White, Specify: Wh	
15-00	in 72 hou n "natura Nedical E	Completed	15. Decedent's Educat (Specify only highest grade c	ompleted)		16a. Deced (Give life. L	dent's Usual kind of work DO NOT use	Occupa done d retired	ation luring most	16b. Kind of Business/Industry				
212	l with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5	(+)	P1umb	er				U	nior	n-Indepe	endent
b	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	-	·						(First, Middle, M	aiden S	Surname)	
/lai	should be tand Mental s marked o umatic eve	일	Laurence Harmel						A1:	ice (Cuno			
ar	2 sho and is ma		19a. Informant's Name/Relationship (Type	Print)		19b. Mailir	ng Address (Street a	and Numbe	r or Rura	l Route Number,	City or	Town, State, Zi	o Code)
رة ح	and Health m 27 her tr		Charles R. Harmel	So							ottingha		nd, 2123 ation - City or To	
Baltimore, Maryland 21215-0036	Pages 1 tment of H tant; If ite jury or ot	5	20a. Method of Disposition 1	noval from State		1and	sition (Name natory or oth Memori	ial	1.1	L - 11-		_	cville	
Ball	permit Depar Impor any in		21. Signature of Funeral Service Licensee	Quick	200	90	2. Name and 9705	Be1	air I	Rd. N	chimunek Nottingh	am,		
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	Examiner	7		Due to (or as										
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P.O. Box (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	☐ Ectopic pre ☐ Other (spe		/			2	3d. Date of deliv	very Day Year
ري ص	w requires that the d sbeen signed by the should be detached		Part II. Other significant conditions contri	_	ut not result	ing in the u	nderlying cau	use give	en in Part I.		23e. Did tobacco use contribute to the cause of death?			
ğ	en sig	ed	PARKINSON:	Dis	EASE	Ξ					1 ☐ Ye	s 2\	Mo 3 ☐ Pro	bably 4 Unknown
Reco	The law re te has be age 2 sho	Completed by									24a. Was ar autops perform 1 Yes	y	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 □ No
ita	ician: The certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
<u>}</u>	Physic this ce al dire		1 ☐ Yes 2 ☐ No	ipital: 1'Umpati			nt 3 DOA		4 L NU		me 5 Reside			ify)
n 0	ding PI h. After t funera	ü	27. Manner of Death ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da		8b. Time of Injury		ic. Injur Work			28d. Describe ho	w injury	occurred	
Division of Vital Records,	or Attendi after death. Director: A in by the fi	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At hom c. (Specify)	ne, farm, str	eet, factory,		Yes 2□		28f. Location <i>(St. City</i> or Towr			al Route Number,
-med	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one)	sian: To the best r: On the basis of and manner st	of examination	ledge, deat on and/or in	h occurred a vestigation,	at the tir	me, date ar pinion, dea	nd place, ath occurr	and due to the c red at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Chavite La	in 1	Resti	dent			e number	O	2		e signed (Month	, Day, Year)
	1		30. Name and address of person who com								- 0:			0 1
	Ų		Bharneet Bha		rar's Signatu		LAVEN	B	00 L L	VAR	D, BALT	MOI	RE, IV)	D-21239
	Sta * Registr		31. Date filed (Month, Day, Year) NOV 1 0 200	27	ar o orgriatu	la .	10	-						
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			For State Registrar	State of Ma	aryiano / L		ficate of I		and Mei	_	grerie Reg. No.	2000	3559	3
	Physicia	an	1. Decedent's Name (First, Middle, L Ella Mae	,					2.	Date of Dea		200 gear	3. Time of Death 2:00 a M	Γ
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4	b. City, Town, or	Location o			4c.	County of Death		_
, sp. der	Funeral Director		*		e (In yrs. last bir		f Under 1 Year Months Days	If Under 2	24 Hrs. 8	Date of Bird (Month, Da ay 24	th	9. Birthp	place (State or Foreign ntry) yland	n
	and ow 1		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										0d. Inside City Limits	-
	e Maryl 3a-f sho	ctor	PA York		Dove	r							1 □ Yes 2½ÇQNo	,
	with the	ıl Dire	10e. Street and Number 1150 Cherry Orcha	ard Road			10f. Zip Code 1731	5			Uni	izen of What Cour ted State America	States	
320	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Mcdrol Everning must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 30 Widowed 4 Divorced	12. Was Decedent I Armed Forces?	Ever in U.S.		s Decedent of Hes, specify Cuba		gin? (Specif , Puerto Ric	y Yes or No can, etc.)		14. Race - Americ Black, White,		
3-003p	72 hour natural'	eted	15. Decedent's l (Specify only highest g		16a.	Deceden	it's Usual Occup d of work done o NOT use retired	ation during most	t of working			ind of Business/In	-	
7 7	l within jiene. r than "	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5	+)		NOT use retired ninistra					ial Secu inistrat		
and ,	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Las	·						First, Middle,	Maiden	Surname)		
ıryıa	es 1 and 2 should be of Health and Mental item 27 is marked or rother traumatic even	욘	Fielder Dorsey In 19a. Informant's Name/Relationship		19b	. Mailing /	Address (Street		Conne		er, City o	or Town, State, Zij	Code)	_
, N	and 2 sealth ar		Michele Stein (Gr				nerry Or							
baltimore	permit. Pages 1 a Department of Hee Important: If item any Injury or othe		20a. Method of Disposition 1XXQurial 2 Cremation 3 4 Donation 5 Other (Spec	cify)		reen	on (Name of ory or other place Mem 1 1 G	rdns	Nov.			csburg, $\mathbb N$		
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	Physician	E 5	2 ka. Payri. Enter the disease, or co sock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir	s tage	not enter		ng, such as	cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner			Due to (or as	a consequ de	of):								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Lue to (or as	a consequence	of):								
>,00/80	tificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	CDue to (or as	a consequence	of):								
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r	The law rec ate has bee page 2 shou	Completed							_	24a. Was auto perfo 1 □Yes	psy ormed?	prior to co	opsy findings available impletion of cause of	е
VITA	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?	Hospital:			2□ DOA Oth	or.		Check only o	one)	7	HOS DICE	_
0	g Physer this eral dir	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		utpatient Time of Injury	3 DOA 28c. Injui	4 🗆 Nu		5 ☐ Resi		6 Other (Speci ry occurred	fy) TIOSPICE	السد
UIVISION	ttendin death. :tor: Aff	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	on			M 1 🗆	Yes 2□I		f Location (Street	nd Number or Rur	al Route Number	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		Physician: To the best aminer: On the basis of and manner st	of my knowledg f examination ar ated.	e, death o nd/or inve	ccurred at the ti stigation, in my o	me, date ar opinion, dea	nd place, an ath occurred	d due to the at the time,	e cause(s , date an	s) and manner as od place, and due t	stated. o the cause(s)	
	Not to t	N	29b. Signature and title of certifier	MO			29c. Licens	se number	35		29d. Da	ate signed (Month,	2008	
	5		30. Name and address of person wh		leath (Item 23a) ろかれき	(Type, Pri	Frence	_ 6	scam	unde	•	MD 2	-114	
I	Sta Registr		31. Date filed (Month, Day, Year) MOV 10	2008 32. Registr	ar's Signature	do	WE !						Day, Year) 2008	

08-08325 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Farhan Iftikhar 1- For State Certificate of Death Registra 2. Date of Death Physician Decedent's Name (First, Middle Last) Month Day November 6, 2008 0940 hrs **Medical Examiner** Farhan Iftikhar **Iftihar** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Tidings Park Launching Perry Point 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** 6 Sev Months Davs Hours Country) Pakistar Director 01/28/1975 33 None 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Yes 2 X No Mercerville NJ Mercer 28a-f show , or items 23a or 28a-f shov r must be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland non of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number United States 08619 97 Edinburg Road Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2X No Yes Asian If Yes, Give Year Yes 2 X No specify: Divorced Specify Widowed event, the Medical Examiner "natural", ð 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Self Employed Importer 17. Father's Name (First, Middle, Last If tikhar 18. Mother's Name (First, Middle, Maiden Surname) Shahista unknown Be Ahmed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m traumatic e 97 Edinburg Road, Mercerville, NJ 08619 Usman Khalid, Cousin 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, other 1 Defense Housing Cemetery 11/09/08 Lahoiore, Pakistan Burial 2 mportant Other Specify Donation 5 Blair Mazzarella Funeral Home 22. Name and Address of Facility T. Harman 723 Coney Island Avenue, Brooklyn, NY 11218 disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I, Enter the **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit law requires that the death certificate be executed Physician/Medical x AMENDED 1 per me, 17 per fh g885 11-7-08 vt UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Hoknowi 23e. Did tobacco use contribute to the cause of death? reate has been signed by page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 26 Place of Death (Check only one director. 25. Was case referred to medical Be examiner? Hospital: Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 this 1 ✔ Yes Inpatient 2 ို 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject witnessed to jump from bridge Nov 6, 2008 0940 hrs Natural Yes 2 V No Pending filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be or Town, State) Southbound Tidings Bridge Route 40, Perry Point, MD determined (Specify) River Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number **OCME** O.C.M.E. November 7, 2008 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** O5 11 2008 9:15p. M William Johnson Leslie /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Manor Care Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 XM 2 ☐ F Months 85 Director 214-14-0709 12 18 MD Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show te notified at Baltimore NA 1X Yes 2 □ No MD Director 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ò death with U.S.A. 21223 1700 Edmondson Ave or items 23a d other than "natural", or items 23a event, the Medical Examinar must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black à 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) I Hygiene. nentary/Secondary (0-12) Resident Custodian Housing permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other that any injury or other traumatic event, Item 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Be Josephine Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 906 North Fulton Ave Apt C, Baltimore Brian Johnson-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 10/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Metro Crematory Inc. March For Horse Servala Md 21215 Baltimore, 4300 Wabash Ave, 26. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im regiate Cause (Final disease or condition resulting in death) **Physician** 1 20 /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 🗌 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D31464 7106 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAW ST Ent 318 BALTIMERE MP 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) 10 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

1 - For State Registrar

Division of Vital Records, P.O. Box 68760.

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Funeral Director		5. Social Security Number 214 38 3861	6. Sex 1 □ M 2 🔭 F		101		nths Days			Date of Birth Month, Day 2/12/1	906	Coun	lace (State or Foreign sylvania		
land Sw		Usual Residence of Decedent 10a. State 10b. County		1	0c. City, Town	or Location	1					11	0d. Inside City Limits		
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I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Michael Eventher inset by notified at other traumatic event, the Michael Eventher inset by notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr		ecedent Eve Forces? s 2 📉 No	er in U.S.	13. Was I If Yes	Decedent of Hi specify Cubar	spanic Origin n, Mexican, P	? (Specify uerto Rica	Yes or No- an, etc.)		Race - Americ Black, White, e			
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and 2 ealth a m 27 is		Edward R. Krepp	(son	ι)	3	10 "A	'st. G	eorge	Road	Essex	Mary	land 2	1221		
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permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service	Licensee	X								eral H			
4 462 60		23a Part I. Enter the disease, o			a doodh Door							aryıan	d 21221 Approximate		
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Attending Physician: It death. ector: After this certific by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	g (Mi	te of Injury onth, Day, \		Time of njury M	28c. Injury Work	rat ? ′es 2 □ No	280.	Describe ho	w injury oc	currea			
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			ng Physician: To t Examiner: On the												
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \cap 1 \cap 2$ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Year **Physician** ONCET /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 11 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Director 214-22-3473 80 1928 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examinar must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Carroll Sykesville Director 1 ☐Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5922 Snowdens Run Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 □Yes 2 √ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√√□No Specify: Specify: white <u>چ</u> 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) health care nursing assistant 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Di Chiara Catherine Palmisano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau once. Joseph La Scuola (son) 5922 Snowdens Run Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 11-12-08 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Pargrafarght Herbert P.O. Box195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumone disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Y Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1 ☐ Yes 2 No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Teath 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician P MOctober 31, 2008 Layton 6:45 E /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Aug. 23, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F 91 **Director** 222-09-0380 1917 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any ilury or other traumatic events. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Montgomery Silver Spring 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 3603 Greenly Street 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕅 No 2 If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur B. Layton ပ္ Mary Hurd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Layton - Wife 3603 Greenly St. Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-5-08 Barratts Chapel Cem. 4 ☐ Donation 5 ☐ Other (Specify) Frederica, DE 21. Signature of Funeral Service Licept 22. Name and Address of Facility
Berry-Short Funeral Home Mum lennes! 119 NW Front St., Milford, DE 19963 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acute Hepatorenal Syndrome /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an was autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Hospice 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 🔼 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760,

P.O.

Division of Vital Records,

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JKouchehou, M)

Jocelyne Kouatchou,

DOO 63748

6001 Muncaster Mill Rd., Rockville, MD 20855

November 1, 2008

08-08293 Phillip Massal

	Please Type or Print in Black Indelible Ink. Ensure All Copi	es Are Legible.										
	State of Maryland / Department of Health and Mental Hygiene											
е	Certificate of Death	Reg. No.										
nt'	s Name (First, Middle,Last)	2. Date of Death										

	R	- For State Certificate of Death	• 0	g. No. 201	18 3559						
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last) PHILIP ROBERT MASSAL	2. Date of Death Month	Day Year	3: Time of Death 1049 hrs						
Wedical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	November	4c. County of Deat							
	L	Howard County General Hospital Columbia		Howard							
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hn Months Days Hours Mir	_	h(MM/DD/YYYY) 9. Bi Fore	ign						
Birector		219 68 8751 12 M 2 F 51 Yrs. Months Days Hours Mir	FEB 2	6 1957 °	ountry) MO						
any	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
Maryland 28a-f show datonce.	<u>.</u>	MO CARROLL FINKSBURG			1 XYes 2 No						
th the Maryland 23a or 28a-f sho notified at once.	֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	10e. Street and Number 10f. Zip Code 2709 APPLE SEE 0 20A0 21048	10	g. Citizen of What Coi	untry?						
vith the s 23a o	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - A										
death v		1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.							
ral", o		3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: W							
2 hours "natu	<u> </u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business	/Industry						
5-0036 5-0036 Tygiene. other than "natura the Medical Exami		12 O LINEMAN		AT 47							
Higie W Higie dothe		17. Father's Name (First, Middle, Last) 18. Mother's Nam 19. And Andrews Name (First, Middle, Last)									
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at once To Bo Commleted by Furneral Director		RAYMONO MASSAL 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or	N KR		te, Zip Code)						
MD d 2 shottlith and n 27 is aumatic		Jean MASSal MOTHER 2.709 APPLE SEED 20a. Method of Disposition (Name of cemetery,									
nore, MI ages I and 2 s nt of Health a nt: If item 27 other traum	ſ	cromaton, or other place)									
드리의등등		4 Donation 5 Other Specify: South CANOI CAEM.	8/2008	WINFIEW	0, MO						
Baltimo permit. Pag Department Important: injury or of	ļ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6026 SYKCOVILLE	VZUMBNI	NEH & MON	my 21284						
Physician		2a. art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and						
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging with Complications			Death						
		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):									
j	<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
ted nsit	<u> </u>	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			+						
and transi		d									
760, icate be executed physician and the burial - transit		UNPENDED AMENDED									
1876 rtificate ing phy as the	- 10	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	23d. Date of delive Month	ery Day Year						
Box 687 death certification at the attending ed for use as the proveician.	riiysiciali	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)									
that the de the by the detached 1		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bbacco use contribute t	to the cause of death?						
PO.			1 Yes	3 2 ✓ No 3 Pr	obably 4 Unknown						
Records, The law require, froate has been sign, page 2 should be			24a. Was autop	sy prior to	autopsy findings available o completion of cause of						
Reco The law cate has	5		1 Yes	rmed? death?							
Vital Rec ysician: The his certificate director, page	n n	25. Was case referred to medical examiner? 1 Ves 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nurs		Residence 6 Oth							
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be partitication: To Be Completed	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	ier.						
Sion (Attending a death. ector: Af by the fur		1 Natural 5 Pending FOUND: Power Nov 1, 2008 FOUND: Nov 1, 2008 POUND: Nov 1, 2008 1 Yes 2 Nov 1 Nov 1, 2008 Nov 1	Subject han	ged himself							
ivisi or Att after de Direct I in by	3	3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, S	state)	Rural Route Number, City						
Divi ospital or . hours after meral Dir y filled in !	4 Homicide (Specify) Sheppard Pratt Hospital [7101 Riverwood Drive, Columbia, MD										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitival for the formulated by Division and Experimental Certification: To Re Completed by Divisional Madical Experimental Filescope and Certification a	leal '	one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	id due to the caus at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)						
To To	ž -	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	fonth, Day,Year)						
		My M, m, D O.C.M.E.		November 6, 2	008						
3		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
Registra		NOVIO 2008 Believe & Aparti									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM Day Year **Physician** MURDY NOVEMBER 6,2008 10:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER OVERLEA REHAB. CENTER **OVERLEA** BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 **X**M 2 □ F Months Hours Min. VIRGINIA 213-72-5605 78 Director 8-18-1930 Usual Residence of Decedent 10b. County show 10a. State 10c. City, Town or Location 10d. Inside City Limits 'natural', or Items 23a or 28a-f shov dicel Examiner must be notified at MD BALTIMORE Director RASPEBURG 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene. 4429 RASPE AVE 21206 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 9 Specify: WHITE 3 Widowed 4 Divorced Completed the Modical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than " Elementary/Secondary (0-12) 5 College (1-4or 5+) DISABLED DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be.
Department of Health and Mental I.
Important: If Item 27 is markany Injury or other any Injury or other. Be UNKNOWN UNKNOWN FRANCES (FRIEZE) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET WITT/ SISTER 4429 RASPE AVE BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY 11-10-2008 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** FAILURE TO THRIVE disease or condition resulting in death) **Medical** Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) 68760, physician Physician/Medical the as attending Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2X No the o. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, SEPSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate Vital 1 □ Yes 2 XNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To o this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 50060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 BACK RIVER NECK ROAD #109 MIDDLE RIVER, MD 21220 PANKAY KHETERPAL 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35602 State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Berrilda Urlie McDonald 8:15 AM 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Smaitlospital Baltmare Baltmore 0-6 If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03 09 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1□ M 25 F 218-23-1764 80 28 Jamaica Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1X Yes 2 No Baltimore MD NA traumatic event, the Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò 21215 U.S.A. 4111 West Rogers Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. or items, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes X☐ No þ Specify: Black 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 10th grade than College (1-4or 5+) Private Duty Nursing Elizabeth Cooney Pages 1 and 2 should be filed vent of Health and Mental Hygient; If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ina Robinson George Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath an Important: If item 27 Is I any injury or other traul once. 4111 West Rogers Ave, Baltimore, Md 21215 Sonia McDonald-Daughter Saltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 11/15/08 Woodlawn, 21/ Signal ve of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 3a. Part/. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infection **Physician** /Medical Due to (or as a consequence of) Examiner leumonic Irmany tract intection Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Chemotheraly MUltiple Multiple Myelma

Due to (or as a consequence of): and Box 68760; physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown Des tension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an nronic p. ge 2 s autopsy performed Yes 2 No he certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 🙎 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. he Funeral Director: After t After t Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number home Del Pasmo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pozoimo 2401 W. Belvedere Batt MD

Registrar

State

chanze

32. Registrar's Signature

Hospital

			1 - State Registrar		-	Cei	rtificate of	Death		Reg. No.		
	Dhysisi		1. Decedent's Name (First, Middle, L.						2. Date of D		Vear	3. Time of Death
	Physici /Medic		John E. Miles	, III	Month Day Year 1.5							
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, o	County of Death	,			
			Union Memoria			timore			N/A			
	Funeral		,	Sex 7. Age 1 M 2 □ F	e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, D	ay, Year)	Cour	lace (State or Foreign try)
	Director		215–12–4649 Usual Residence of Decedent		90	118.			July !	5 , 19	18 Mary	land
	and and		10a. State 10b. County		10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits
	/aryl	ō	Maryland N/A		Balt	imo	re					ty⊠Yes 2∐ No
	the N	rec	10e. Street and Number				10f. Zip Code			10a. Citi:	zen of What Coun	trv?
	with 3a or	Ö	4299 Falls Road					21211		9		,.
	ns 2	era	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. \			n? (Specify Yes or N Puerto Rican, etc.)	0-	USA 14. Race - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a flydical Evanifier must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2★Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ★★es 2 □ N If Yes, Give Year or Dates:	No		fYes, specify Cuba I∐Yes 2 XX Io	an, Mexican, F Specify:	Puerto Rican, etc.)		Black, White, e	^{etc.} hite
2-00	72 hour	eted	15. Decedent's E (Specify only highest gi	ducation	16a	. Deced	dent's Usual Occup	pation	f working	16b. Kir	nd of Business/Ind	dustry
21215-0036	within ene. than "	omple	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done DO NOT use retired S Person	d)	Working	Off	ice Equi	nmant
Q Q	filed Hygi sther	ပ္သ	17. Father's Name (First, Middle, Las	t)		Jule	D I CLISOII	18. Mother's	Name (First, Middle			pillent
Maryland	ld be lental ked c	To Be	John Miles,	Jr.				Anr	na La Bont	- Θ	,	
ary	shou ind M imar umat	-	19a. Informant's Name/Relationship	(Type. Print)	198	o. Mailin	g Address (Street		or Rural Route Numi		r Town, State, Zip	Code)
ž	alth a alth a 27 is		Josephine R. Mi	les Wife		4	299 Falls	s Road,	Baltimor	e, Ma	arvland :	21211
ē,	item item		20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of natory or other plac	ne)	Date		cation - City or To	
E	Page nent (int; if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State	Atla	nti	c Cremato	ory 11	/08/2008	Gler	n Burnie,	, Maryland
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service Lice		1	22	. Name and Addre	ss of Facility	itz Funer			
<u> </u>	8 3 2 8 8		Jum !	3. Hen	21)		3631 Fall	enss-se Ls Road	l, Baltimo	al Ho	ome, Inc. Maryland	. 21211
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ent	er the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
4	Physician	i	Immediate Cause (Final disease or condition	· Inc	men	ia	de Se	atic	Short	1		Onset and Death
J.	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						7
	Lammer	<u>.</u>	Sequentially list conditions,	b								4
W	ted sit	Examiner	cause. Enter Underlying	Due to (or as	a cunceyus its	ot).						
F.	execu and al-trar	xan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence	of);						
68760,	ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit			`								
687	ificate g physis the	Medical		d								
	0 2 0		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of <u>pregnancy</u>					2	23d. Date of delive	erv
m.	death e atte d for	Physician	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death		Ectopic pregnanc Other (specify)	У				Day Year
<u>Р</u> О	t the by th	hys	9 ☐ Unknown	9 🗆 Unknown								
S,	The law requires that the death ate has been signed by the atter age 2 should be detached for u	by P	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to th	ne cause of death?
Records,	w require been si should t								1 🗆	Yes 2	□ No 3 □ Prob	ably 4 Unknown
ပ္ထ	e law re has be	Completed							24a. Was		24b. Were auto	psy findings available
ř	The ate has bage	E O							auto	ormed?	death?	mpletion of cause of
a	lan: rrtifica	Be C	25. Was case referred to medical					26. Place of	Death (Check only		I La les	2 🗆 140
>	nysic nis ce direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ER/O	utpatien	t 3 DOA Oth	er: 4 🗆 Nursi	ng Home 5 Res	idence 6	G ☐ Other (Specifi	v)
0	ding Physician: The n. n. After this certificate h. funeral director, page	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	ry 28b.	Time of Injury	28c. Injur Worl	y at k?	28d. Describe	how injury	y occurred	
0	endin sath. or: A the fu	atic	2 ☐ Accident investigation	n				Yes 2 □ No				
Division of Vital	or Att ter de irect n by t	Certification: To	3 ☐ Suicide 6 ☐ Could not to determined		ry - At home, fa c. (Specify)	arm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Rura)	l Route Number,
	ital c	S										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination ar	e, death nd/or inv	occurred at the tile vestigation, in my control	me, date and popinion, death	place, and due to the occurred at the time	e cause(s) , date and	and manner as s place, and due to	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			_	29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
			De lockon	vain 1	1.D.		AT2	432	3946	110	V 74h	2000
	10		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, I	Print)			, 00	v)	2008 re, MD-
	10	1	FAHMI RAHN	IAN M.E).	mi	on Me	MION	al Hos	D. 12	affino	re, MD-
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	A	-8		110-3	11		

DHMH 17 Rev 1/2001

Registrar

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			1 - State Registrar		yland / De	ndelible Ink partment of F ertificate of	Health and N	-	_	0 8	35604
	Physici /Medi	cal	Nicholas Vincent Ore As Facility Name (If not institution, give street)			Ab City Toylo	r Location of Death	2. Date of De Month Novembe	er 6, 20		3. Time of Death 10:10 P M
	Examir	ner -	Stella Maris Hospice			Timonium			Balti		
	Funeral Director		5. Social Security Number 6. Sex 1		n yrs. last birthda Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 28	rth ay, Year) 3, 1923	9. Birthpla Count P	ace (State or Foreign ry) ennsylvania
_	laryland show	ō	10a. State 10b. County		Oc. City, Town or					10	d. Inside City Limits
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	eath w	eral	5846 Westwood Avenue	as Decedent Eve	r in II S 1	21206	lienanie Origina (Sr	posify Vas or No	USA 14 Bas	e - America	un Indian
	be filed within 72 hours after death with the Maryland the Hygiene. Id other than "natural", or items 23a or 28a-f show event, in the life of the land	ò	1 Never Married 2 Married 1	med Forces? ☐Yes 2 ☐ No /es, Give ar or Dates:	11110.3.	3. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🕅 No	Specify:	Rican, etc.)	Specify	k, White, et	tc.
208 1215-0036	within 72 ho iene. than "natur ne Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	oleted) ollege (1-4or 5+)	16a. De (Gi	cedent's Usual Occup ve kind of work done e. DO NOT use retired	pation during most of work d)	king	16b. Kind of Bi	usiness/Indu	ustry
22	filed withi Hygiene. other thar		12		Longs	shoreman	10. Mathava Nam	- /First Middle	Shippi		
) Laboratory	Mer arke	To Be	17. Father's Name (First, Middle, Last) Massimo Orefice	7.0	<u> </u>		18. Mother's Nam	allone			
N Par	5 # C T		19a. Informant's Name/Relationship (Type. Pr Massimo Orefice /	son		alling Address <i>(Street</i> Westwood					Code)
NOVEMBE Baltimore. N	ges 1 and to the lift item		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Remov	al Irom State		position (Name of rematory or other place		Date	20c. Location -	City or Tow	vn, State
	permit. Pages 1 Department of F Important: If ite any Injury or ot		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ricenses	-	Dulaney Va	alley Mem Gar 22. Name and Addre		.0/08	Timoniu 1050		Road
200	Perr Perr Perr Perr Perr Perr Perr Perr) Potal (ley	1	Ruck Towso	n Funeral	Home			21204
4	Physician /Medical Examiner			s he't caused the secon each line. UN C Due to (or as a co	in CA	NCEP	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760.	icate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a co				. 45			
EFICE P.O. Box 6	ath cerl	Physician/Medic	in the past 12 months?	res, outcome of public live birth 2 live Pregnant at time linknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			e of deliver	y Day Year
-1-	quires that the de	ģ	Part II. Other significant conditions contributi	ng to death but no	ot resulting in the	underlying cause give	en in Part I.				cause of death?
<i>otAS O</i> l⁄	aw asb	Completed	OF Management and the last					1 □ Yes	ormed?	Were autops prior to com death?	sy findings available pletion of cause of
3 ₹	nysicla nis certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospita	l: 1 🗆 Inpatient	2 ☐ ER/Outpat	ient 3 □ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		one) dence 6 ⊋Oth	er (Special	OFICE
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∭ Division	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 286	Place of Injury - building, etc. (S	At home, farm, s Specify)	street, factory, office	Yes 2□No	28f. Location (: City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
	he Hospit in 24 hours he Funera ipletely fille	Medical (29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner; Cond Number of ACT IT 1)	To the best of mention the basis of exiculting the basis of exiculting the basis of	ny knowledge, de amination and/or	ath occurred at the tir investigation, in my o	me, date and place, ppinion, death occur	, and due to the red at the time,	cause(s) and madate and place,	anner as sta and due to t	ated. the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	WP		29c. Licens	e number 19792	_	29d. Date signer	(Month, D	ay, Year)
	7+1	,	TACKIE JUNES CAN	ed cause of death	DULANE	e, Print) Y VALLEY	RD TU	MONIU	M, MD	2109	13
	Sta Registr		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) NOV 1 0 2008	22. Registrar's	Signature Signature	who					

			For State	State of M	larylan					and M	ental Hy	/gien	e	2.0		
		_	Registrar 1. Decedent's Name (First, Middle, Last			Ce	rtificate	e or L	Jealn		2. Date of De	Reg. No	0.20	18	3. Time o	505
	Physicia	an		ecora							Month Novemb	Da	ay 200	Year		2 p M
-	/Medic		4a. Facility Name (If not institution, give		r)		4b. City.	Town, or	Location of		NOVELIIL		c. County o			<u>- P</u>
	Examin	er	1024 S. Decker Ave				Balt						, .			
	Funeral					last birthday	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Bi	rth	1	9. Birthp	lace (State	or Foreign
	Director		213-26-9131	JM 2□F		78 Yrs.	Months	Days	Hours	Wiln.	Apr 24	, 19	30 1	Mary	Tand	
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or L	ocation							11	Od. Inside C	City Limits
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	28a-	Director	MD 10e, Street and Number		ватт	imore	10f. Zip	Code				10g. C	itizen of Wh	nat Coun	try?	
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	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the "K-dicol Evan her must be neithed at event, the "K-dicol Evan her must be neithed at	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	.S. 13.			spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)		14. Race			
٥	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ⚠ Yes 2 ☐ If Yes, Give] No		1 ☐Yes 2		Specify:		nican, etc.)			, White, e		
1215-0036	ural",	d by	3 ☐ Widowed 4 🕅 Divorced	If Yes, Give Year or Dates	1951-								Specify:			
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7	withir ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or	5+)	Contr		e remeu,	,			Con	struc	tion		
2	filed Hyg other ent, I		17. Father's Name (First, Middle, Last)			1001.01			18. Mothe	er's Name	(First, Middle					
land		To Be	Frank Pecora						Mary	Celi	io					
Mary	ges 1 and 2 should be it of Health and Mental If item 27 is marked or or other traumatic ev		19a. Informant's Name/Relationship (7)			19b. Mail	ing Address	(Street a	and Numbe	er or Rura Rolt +	i Route Numb	ber, City	or Town, S	State, Zip	Code)	
2`	and and fealth m 27 in her tr		Dawn Pecora/daugh	rer												
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g D	permit. Pages Department or Important: If i any Injury or once.		21. Signature of Funeral Service Licens	La Atto	MO1	G 1251 R	oing T	iome°	Crem	ation	n Servi	ice C1	P.O.	Box	: 784 MD	21020
			23a. Part 1. Enter the discase, or comp	lications that cause	ed the deat	h. Do not er	ever ty	e of dyin	g, such as	cardiac o	r respiratory	arrest,	arksv	1116	Approxima Interval Be	ate
-	Physician		shock, or heart failure. List only o Immediate Cause (Final			D									Onset and	
-	/Medical		disease or condition resulting in death)	a. Coronar Due to (or a			Isease	2								
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XOD	w requires that the death certifictions is been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								Į	23d. Date	of delive	ery	
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cords	requi	Completed										Yes :	Z [] 180 3	3∐ FIOL	ably 4 🗌	OTIKTIOWIT
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0	g Phy er this eral d	ا: <u>1</u> 0	27. Manner of Death	28a. Date of In	ijury	28b. Time		8c. Injury	y at		28d. Describe				<u>y)</u>	
<u> </u>	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	Jay, Year)	Injury	М	Work	r Yes 2□	No						
DIVISION OF	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	njury - At h	ome, farm, s	reet, factory	, office		2	28f. Location . City or To			r or Rura	l Route Nu	mber,
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 2 Medical Exam		of examina											(s)
	Fo the within Fo the complex c	Me	29b. Signature and title of certifier				290	. License	e number		-	29d. D	ate signed	(Month,	Day, Year)	
			PENAL M	· Vanc	ON.	D		DS	507	70)	Nov	ember	5,	2008	
,	141		30. Name and address of person who c	ompleted cause of	death (Iter	n 23a) (Type			1.	, ,	-					
	5			largo	MD	/	000	Eas	+ Ea	rger	St., I	Bal	timor	e, N	1D Z1	202
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11-02-2003 **Physician** 700 A M Mary Elizabeth Powers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛱 F Months Days Hours Min 06-12-1933 Director 75 147-24-0942 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c City Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 1013 Alexandria Way Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care 12 Vice President 7 is marked other traumatic event, the Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathleen Landers Joseph B. Boylan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Alexandria Way Bel Air, MD 21014 Edward Powers (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ignatius Cemetery 11-06-2008 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rarhinsons disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be execut burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 □ Yes 2 □No Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 Accident investigation 1 □Yes 2 □No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examiner: NURSE PRACTIFIATIVE ON THE PRACTIFIATIVE OF THE (Check only nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-R157629 11/03/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 JENNIFER HAUF, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32 Segistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

2008

NOVEMBER

POWERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 49 M ralas Nov 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Bultimer of maryland medical cente ear If Under 8. Date of Birth (Month, Day, OCT • 6 • Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2□F Months Days Hours Y2961 220-88-1231 47 MD. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner must be notified at XXYes 2 □ No Director MD. N/A BALTIMORE the 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Modical Examinations. 1 W. CONWAY ST, APT. 704 21201 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Yes, Give Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOME IMPROVEMENT PAINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM C. PERRY, JR ROSALIE C. LANNON မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 1 W. CONWAY ST., APT. 704, BALTIMORE, MARYLAND ROSALIE PERRY/MOTHER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ATLANTÍC CREMATORY 11/04/2008 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. Even 6224 EASTERN AVE., BALTIMORE, MARYLAND 28a. Part 1 / ntyr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate = use (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** hv /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 □Yes 2 □No After this certificate has been signed by the funeral director, page 2 should be detached to 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 🖺 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury ↑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

P.O. Box 68760. Records. Division of Vital

Baltimore, Maryland 21215-0036

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State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2008

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DHMH 17 Rev 1/2001

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

700x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Arnold Kay 7:30 PM November 2001 /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital TIMOLE Harbor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) May 5, 1963 9. Birthplace (State or Foreign Sex M 2□F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Maryland 45 216-66-4672 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21227 4433 Fenor Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineering Consulting Engineering Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Marie Feuchtenberger Arnold Eugene Ray, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4431 Fenor Rd. Baltimore, MD 21227 19a. Informant's Name/Relationship (Type. Print) Theresa Marie Ray/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ament of He 20a, Method of Disposition = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any Injury or Chesapeake Crematory 11/07/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part1. Enter the prease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart silure. List only one cause on each line. **Complications of diabetes mellitus** Immediate Cause (Final Physician MERROYED BY MEDICAL EXAMINER disease or condition resulting in death) 1000 /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year ō 5 ☐ Other (specify) 4□Pregnant at time of death the 9 I Inknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Wellitus 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Atherosclerotic cardiovascular disease; Chronic pade Yes 2 ☐ No Narcotic use 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2∑ No 1' Inpatient 2 ER/Outpatient 3 DOA ပို After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohindalih A.M Sohaib 5. BAHIMCRE, MD 3001 HANGVER ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND item#30 perDVR G885, 11/10/08 ws#29 c
State of Maryland Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Rita **Physician** 12:45 PM october 31 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Amberwood Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-18-1954 9. Birthplace (State or Foreign 6. Sex . Social Security Number 7. Age (In yrs. last birthday) **Funeral** MARY Land Days Min. 1 □ M 2 🗹 F Hours 217-58-7268 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland und Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐Yes 2 ☐ No Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh
Injury or other traumatic event, the Medical Examiner must be notified
once. Baltimore Directo Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Amberwood Steed 21206 6024 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health e 4194RAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Begett Bealtice ۹ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an 9238 Woodcreek Barto. md. (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 □Removal from State 1 🗆 Buria/ 2 Cremation Balto. 08/2008 view Crematary 4 □ Doylation 5 □ Øther (Specify) Broadway bease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or lure. List only one cause on each line. Approximate Interval Between Onset and Death spiratory arrest, mediate Cause (F) al Physician ocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronar. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence if): The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the and do not be detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No 24a. Was an autopsy performed? page 2 after death. or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D44315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Medical Group Vincenzo Grippo Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008 0

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** CONGIE RIZZO 11:30 NOVEMBER 6 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8110 CANDLE LANE ROSEDALE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year) Min. Months Days Hours 1 □ M 2 🔀 F 214-14-4328 96 Yrs 2-22-1912 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes XXNo BALTIMORE MD ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 8110 CANDLE LANE 21237 U.S.A. 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Ş Q 3 Widowed 4 □ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) COOK CATERER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TONY **GENOVESE** DOMENICA (CURRIER) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARMELA RIZZO/ DAUGHTER 8110 CANDLE LANE ROSEDALE, MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State HOLY REDEEMER CEM 11-10-08 BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licer 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Examil and A that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 s certificate 2 00 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6} \boxtimes$ Other (Specify) DAUGHTER † S Hospital 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 HOUSE 5 ☐ Pending investigation 1 Natural in 24 hours after death.

he Funeral Director: Aft
pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1321022 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLIN and BALOUND 21236 Kuralouga M2 7602

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 17: 40 PM Hedwig Schlachta November 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Sinai Hospital of Baltimore Poate of Birth (Month, Day, Year) Feb 20, 1922 Schlachta, Hed If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 204-24-7657 Poland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Madical Examiner nost be notified at YYes 2 □ No Director Philadelphia Philadelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is marked other than "natural", or items 23a or 19111 USA 6016 Bingham Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No þ Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 should be filed within and Mental Hygiene. College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stefan Bruch Marie (unk) 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Loretta Schlachta-Fairchild 6935 N. Clifton Road Frederick, MD 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/11/08 Beltsville, MD Coing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signatore of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung cancer month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Lym phoma month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of physician and strans The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by pulnonari 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? Yes 2 No director, page 1 □Yes 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) deena M. B. B. S November, 4, 2008 RES-000 20 2401 W. BELVEDERE AVE BAH. MORE, M.D 2175 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE

Registrar DHMH 17 Rev 1/2001 JEENA SANDEED MBBS

2008

NOV 1 0

31. Date filed (Month, Day, Year)

Patient

32. Registrar's Signature

8-08361 Antoinette Jo Sca	arar	Please Type							gible.			
		I- For State Registrar	e of Maryland		icate of De		io ivientai F	F	tog. 140.	008 3561		
Physicia Medical Examir		Decedent's Name (First, Middle, L ANTOINETTE As Facility Name (if not institution, g	,	<u> </u>	SCAR A		IO	2. Date of Dea Month Novembe	Day Year	1502 hrs		
)		Franklin Square Hospital	,		1	sedale			Baltimore			
Funeral Director		212-28-8023	Sex 7. Ag	e (In yrs. last t		Under 1 Ye onths Da		n		9. Birthplace (State or Foreign Country) MD		
faryland 28a-f show any 1 at once.	_	Usual Residence of Decedent 10a. State 10b. County MD BAI	TIMORE	10c. City, Tov	wn or Location		ROSEDAI	LE		10d. Inside City Limits 1 Yes 2 X No		
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 6725 FORDCRES	T ROAD		101	. Zip Code	21237		10g. Citizen of Wha	st Country?		
death with or items 23 must be no	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces? 1 Yes 2		If Yes, s	pecify Cuba	ispanic Origin? (\$ in, Mexican, Puert			American Indian, Black, etc.		
ns after ural",	হ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:	npleted) 16		2X N	o specify: ation (Give kind of	work done	Specify: 16b. Kind of Bus	WHITE iness/Industry		
1215-0036 d be filed within 72 hours after death with the Maryland fental Hygiene. staked other than "matural", or items 23a or 28a-f sheevent, the Medrel saminer must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or			f working lif	e. DO NOT use re		HAUSS	SNER'S CUARANT		
215-0036 be filed within 7 ntal Hygiene. 'ked other than		17. Father's Name (First, Middle, La							Maiden Surname)			
2121 Duld be fill Mental I. marked	To Be	EMIL 19a. Informant's Name/Relationship		OREL	19b. Mailing Add	iress (Stre	MARII et and Number or		(NAUYA) mber, City or Town			
MD nd 2 sho alth and m 27 is aum at	1	THOMAS SCARAN	TINO/HUS				REST RO		SEDALE,			
Ore, ges 1 ar t of Her ther tr		20a. Method of Disposition 1 X Burial 2 Cremation	Removal from St	ate cren	e of Disposition natory or other p	lace)		Date		City or Town, State		
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked o	1	4 Donation 5 Other Specify: GARDENS OF FAITH C 11-12-08 BALTIMORE, MD 21 Sunature of Funeral Service Licensee 22 Name and Address of Facility CVACH/ROSEDALE FUNERAL										
	*	ا حاد			11211	CHE	SACO AV	E ROS	SEDALE,	MD 21237		
Physician /Medical		23a. Part I. Enter the disease, or cor failure. List only one cause on	each line.		not enter the m	ode of dying	ı, such as cardiac	or respiratory ar	rest, shock, or hear	Approximate Interval Between Onset and Death		
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a cons			-				- Joann		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):								
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an and		UNPENDED	dAMENDED									
tox 68760, eath certificate be exe attending physician a for use as the burial -	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	me of pregnan	2 Fetal de		Ectopic pregr	nancy	23d. Date of o	delivery Day Year		
Box ne death r the atte	hysic	1 Yes 2 No 9 V Unknow			5 Other	(Specify)						
P.O.	ā	Part II. Other significant condition	s contributing to deat	h but not resul	ting in the under	lying cause	given in Part I.			oute to the cause of death? Probably 4 Unknown		
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Reco	dwo							auto perf 1 ✓ Yes	ormed? de	rior to completion of cause of eath? Yes 2 No		
tal Recinnii The certificate	Bec	25. Was case referred to medical examiner?	Hospital:			-	e of Death (Chec					
of Vit ing Physic After this	의	1 Yes 2 No 27. Manner of Death	Прин		Outpatient 3 b. Time of Injury	DOA 28c. Inj	Other Nurs	ing Home 5	Residence 6 how injury occurre	Other:		
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Division of Vital Records, pital or Attending Physician: The law require ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could no	ot be 28e. Place of Ir		, farm, street, fa	ctory, office	building, etc.			r or Rural Route Number, City		
spi hou fil	Medical Ce	29a Certifier	ician: To the best of m		death occurred a			nd due to the cau	use(s) and manner a	as stated.		
To with To 1	Med	29b. Signature and title of certifier	and manner stated.				se number			d (Month, Day, Year)		
		hy his,	ngo			O.C	.M.E.		November 8	3, 2008		
10		30. Name and address of person wh Ling Li, MD Assistant	o completed cause of d Medical Examine	,	enn Street, B	altimore	MD 21201					
Sta	ite	31. Date filed (Month, Day, Year)		r's Signature	F . 100					·		

DHMH 17 Rev 1/2001 OCME 2006

	1 - State Registrar	
	1. Decedent's Name (First,	Midd
n	Anna	

35613

Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medica camine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		Registrar				Cer	titicat	e or L	eatn			Reg. No). L 0 0 '	0 000	10
hysicia	e in	1. Decedent's Name	(First, Middle			C					Da	Day Year			
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	2-	Keswick				lant histoday)					P. Data of F	lieth	0.0:	theless (Ctate as Fee	
unerai		5. Social Security Nu		6. Sex 1 □ M X □ F	7. Age (In yrs.	Yrs,	Months	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)) C	thplace (State or Fore	reign
rector		216-22-3			99	113.					01]	.9 (09	VA	
>	1	Usual Residence of D	Decedent 10b. County		10c Cit	ty, Town or Lo	ocation							10d. Inside City Lin	mite
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Ba-f ptifie	ct	MD	NA	•	ь	altimo									
or 2	Ä	10e. Street and Num					10f. Zip					10g. Cit	tizen of What C	•	
23a Ist b		3344 Mon	dawmi	n Ave				21	216			U.S.A.			
ems er m	Funeral Director	11. Marital Status		12. Was Dec Armed F	cedent Ever in U	J.S. 13. \	Was Deced	lent of His	spanic Ori	igin? (Spen, Puerto	ecify Yes or i Rican, etc.)	Vo-	14. Race - Ame Black, Whi		
or it	딘	1 Never Marrie		ied 1 ☐ Yes If Yes, G	2X No ive		1 □ Yes		Specify:		,			Black	
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natu	Completed	(Specif	 Decedent y only highes 	t's Education st grade completed,	16a. Deced	dent's Usua kind of wo	al Occupa rk done di	tion uring mos	t of worki	ing	16b. K	(ind of Business	/Industry		
Me	ם	Elementary/Second	_ , , ,	College	(1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)						Privat	_		
t, th	흥	12th gra		<u>na</u>		D	omes		40.11.0		(F)			e	
d oth	Be	17. Father's Name (F		,							(First, Midd		n Surname)		
arke	္	William Jones Laura Gailoway													
aum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
er tr		Julius W	addy-	Son						e, B	altin	nore	, Md	21215	
roth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											r Town, State		
nt: If		TO Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Park 11/12/08 Arbutus, Md													
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exa <u>miner must be notified at once.</u>		21 Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215													
a a		/ > XUIN	Mua	U. SALIN	N/M	43	oo''w	abas	h A	ve,	Balti	imor	e, Md	21215	
		23a. Part1 Enter the	disease, or	complications that	caused the deal	th. Do not ent	er the mod	e of dying	j, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between	
alalan		mmediate Cause (F		only one cause on	each line.		0	. 1	.1 .					Onset and Death	h
sician edical		disease or condition resulting in death)		a. Buo to	o (or as a consec	age	Ren	u	6145	eas	l_			Years	
miner				Due to	(or as a consec	quagece on).								'	
	<u>-</u>	Sequentially list conditions if any, leading to imp	ditions, nediate	b. — Due to	o (or as a consec	quence of):									
nsit /	Examiner	Sequentially list condificant, leading to immodule cause. Enter Underling Cause (Disease or in	ying ijury	S											
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phys s the	n/Medical			d											
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atten for u		23b. Was decedent in the past 12 n		1 ☐ Live		aldeath 3□	Ectopic p						Month	Day Year	
the	Physicia	1 □ Yes 2 🗓 9 □ Unknown	No	9☐Unki		death 5L] Other (st	ecny/			-	-			
d by letac	F.	Part II. Other signific	eant condition	ons contributing to	death but not res	sulting in the w	nderlying c	ause nive	n in Part I	1.	23e. Die	d tobacco	use contribute t	to the cause of death	1?
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ortific otor,	a)	25. Was case referre	to medical	I					26. Place	of Death	(Check onl				
direct	To B	examiner? 1 ☐ Yes 2 ☐	lo	Hospital: 1] Inpatient 2] ER/Outpatier	nt 3 🗆 DC	Othe	r: 4 N	ursing Ho	me 5□Re	sidence	6 □Other (Spi	ecify)	
ter th		27. Manner of Death		28a. Date	e of Injury nth, Day Year)	28b. Time o	f 2	8c. Injury Work	at		28d. Describ	e how inju	ry occurred		
r: Af e fur	읉	1 M Natural 2 ☐ Accident	5 Pendin investig	9 1	nun buy rour	,,	М		′es 2□	No					
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d in	Certification:	4 Hornicide	/	Bulk	ding, etc. (Speci	iiy)					City of 1	Fown, Stat	e)		
y fille				ng Physician: To th											
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one)	∠ ∐ Medical	Examiner: On the and ma	basis of examin nner stated.	ation and/or in	vestigation	, in my or	oinion, de	ath occur	red at the tim	ne, date an	nd place, and du	ue to the cause(s)	
To th	Me	29b. Signature and t	we of certifie	r			29	. License	number	_		29d. Da	ate signed (Mor	nth, Day, Year)	
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_		30. Name and addre	ss of nerson	who completed car	se of death (Ite	m 23a) (Tyne	Print)	1)	100	//		14	JVELLE	er 6, 20 2004	
2		Andre	5 6		76	7 1 1		a R	d.	911	, 14	cit.	NIT	2/04	7
Sta	te	31. Date filed (Month	n, Day, Year)	1/42 gr	Registrar's Sign	ature	1901	1 /\	~/_	6111	4011	U114	(1010	- Clut	-
Registr		NOV	1 0 20		A SAN	STONE STONE	10 Charles					,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Owen Stowars, Sr. Day Month Year ovember 2008 90 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) XX M 2 F Months Days Hours Min 213-46-0490 60 Director Dec 10, 1947 Balto, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1329 West 40th Street Funeral 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Artho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: ð Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal any foliary. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Service Rep 12 BCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Stowars ပ Reba Harold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Stowars (Wife) 1329 West 40th Street MD 21211 20c. Location - City or Town, State Balto. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XX emation 3 ☐ Removal from State Atlantic Crematory 11/7/08 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Caused Final. Funeral Home, alto, MD 21211 Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner equence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar union resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sal director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 2 1 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner⁴ Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

•eral Director: # 2 Accident investigation 1 ☐Yes 2 ☐ No ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier unucory 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ICULICATEN MEMORIAL UNION 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

		For State Registrar				artment of F rtificate of		a wentarr	Reg. No. 2	008	356
Physicia /Medica	al .	1 Decedent's Name (First, Middle Elaine	D.			Sulliva		2. Date of E	6 Day	Year Z008	3. Time of Death
Funeral Director		216-74-4675	ngton Medic			4b. City, Town, o	If Under 24	Hrs. 8. Date of E	4c. Cou	9. Birthp	place (State or Fore
e Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arunde1	10c. City,	Town or Lo						0d. Inside City Lin
eath with the is 23a or 2 must be in	Funeral Dire	10e. Street and Number 23 Cedar Drive	12. Was Decedent	Ever in LLC	12.1	10f. Zip Code 210		2/0	10g. Citizen of What Country? U.S.A. or No- 14. Race - American Indian,		
ours after d	ò	11. Marital Status 1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	No		Was Decedent of H fYes, specify Cuba 1 □Yes 2ሺ No	an, Mexican, Pi	? (Specify Yes <i>or</i> Nuerto Rican, etc.)	Spe	Black, White, e	etc.
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Exprince must be notified at	Completed	15. Decedent (Specify only highes: Elementary/Secondary (0-12)	s Education f grade completed) College (1-4or 5	5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired Homemake	during most of d)	working	16b. Kind o		
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f Health and tem 27 is m		19a. Informant's Name/Relationsh Michael L. Sull 20a. Method of Disposition	ivan (Husb		23 C	ng Address (Street Cedar Dri sition (Name of the place of the place)	ve Glen		Maryla	,,,,,,	60
permit. Pages: Department of I Important: If ite any Injury or of once.		1 ☐ Burial 2 【A Cremation 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecify)		view C	natory or other place Crematory Name and Addre Cully-Po	ss of Facility	/07/08	Baltim	ore, M	aryland
	Ĭ	23a. Part I Inter the disease, or on shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	a conseque	Do not entering of the control of th	04 Mount	ain Roa ng, such as can	d Pagado	na Mar	yland	211.22 Approximate Interval Betwee Onset and Deat
death cer e attendir d for use	Tysician/Imedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnanc	у		1	Date of delive Month	iry Day Year
igne be d	2	Part II. Other significant condition	s contributing to death bu	ut not resulti	ing in the un	derlying cause give	en in Part I.		tobacco use co		e cause of death
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io the hospital of Attending Physician: The law within 24 burs after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 with the funeral director. The Be Commit	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of Inju (Month, Day	ry 2	9/Outpatien 8b. Time of Injury	t 3 DOA Other	^{er:} 4 □ Nursin y at	g Home 5 Res 28d. Describe			()
To the Hospital or Attending F within 24 hours after death. To the Funeral Director. After completely filled in by the funeral Machical Certification.		3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Cettifier 4 Certifier	ed 25e. Place of Inju- building, etc	c. (Specify)	edge, death	occurred at the tir	ne, date and pl	City or To	e cause(s) and	manner as si	Route Number,
vithin 24 houndly to the Funel completely fill	Medic	(Check only one) 2 Medical E 29b. Signature and title of certifier	xaminer: On the basis of and manner sta	examination	n and/or inv	29c. License	pinion, death o	ccurred at the time	29d. Date sig	e, and due to	the cause(s) Day, Year)
	- 1		/10// 1 MM 1	X) CA GA	1	リワ	950		MALLAN	Alexa 1	6, 2008 Ne WD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

elor	es Stanton	1	State of Maryland / Depar - For State Cert.	tment of l ificate of i		ital Hygiene Reg. 1	n 20	02 3561
	Dhuricia	R	tegistrar 1. Decedent's Name (First, Middle,Last)	modito or .		2. Date of Death	THE STATE OF	3. Time of Death
led	Physicia ical Examin			Stanton	UG	Month Da October 30, 2		1814 hrs
1			4a. Facility Name (if not institution, give street and number)	4t	City, Town, or Location	of Death .	4c. County of Death Baltimore Cou	
			395 Butler Road		Reisterstown	er 24Hrs. 8. Date of Birth (N	MM/DD/YYYY) 9. Bir	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 212–38–2351 1 M 2x F 68	st birthday) Yrs.	Months Days Hours		Forei	gn puntry)PA
		Ŀ	Usual Residence of Decedent					10d. Inside City Limits
	v any		10a. State 10b. County 10c. City,	Town or Location	on			1 Yes 2 X No
	Aaryland 28a-f show 1 at once.	ē	MD Baltimore		Reisterstown 10f. Zip Code	n 10g.	Citizen of What Cou	untry?
0	Mary r 28a- ed at	Director	10e. Street and Number				U.S.A.	
6	ith the 23a o notifi		395 Butler Road 11. Marital Status 12. Was Decedent Ever in U.S.	S. 13. Was	21136 Decedent of Hispanic Or	rigin? (Specify Yes or No-	14. Race - Ame	rican Indian, Black,
14	5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Ye	es, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.	
/	fter de		3 X Widowed 4 Divorced If Yes, Give Year		Yes 2 X No specify			Mite
	ours a	d b	io. Beddedinto Eddedinto (Epito), in j	16a. Decedent	's Usual Occupation (Given ost of working life. DO NO		6b. Kind of Business	/Industry
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	5-003 iled within Hygiene. I other th	Completed	12 17. Father's Name (First, Middle, Last)	Cas	shier 13.Mothe	er's Name (First, Middle, Mai		
		BeC	Samuel Austin Jones			Blanche		arben
	2121; ould be fil Mental I marked c event, i	To B	19a. Informant's Name/Relationship (Type, Print)	117		umber or Rural Route Numbe		
	and 2 shoul tealth and N tem 27 is n traumatic		Louis Scott Stanton Son	6520 \$	Spelling Bee	Court Colum	nbia, MD 20c. Location - City of	21045 or Town, State
	ore, M es 1 and 2 of Health If item 2 her traum		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	Place of Dispos crematory or oth	ition (Name of cemetery, ner place)	Date	.oc. Zoodion ony	, , , , , , , , , , , , , , , , , , , ,
	Page nent o		4 Donation 5 Other Specify: At 1		Crematory		Glen Burn	
	Baltimore, permit Pages I au Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service Licensee		lame and Address of Facil	HOME Reister	isterstow	
		_	23a. Part I. Enter the disease, or complications that caused the death	. Do not enter t	TINE FUNERAL ne mode of dying, such as	cardiac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
	Physician 'M. Jical		failure. List only one cause on each line.					Death
	aminer		or condition resulting in death) Due to (or as a consequence or	f):				
			Sequentially list conditions, b. ALcoholism	*				+
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-1		хап	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	ıf):				
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	60, e be e. ysician burial	ledical	Alexa de la companya	nancy			23d. Date of deliv	rery
	6876(certificate nding phy	ian/M	23b. Was decedent pregnant in the 1 Live birth	2 F	etal death 3 Ecto	opic pregnancy	Month	Day Year
	Box 68760, e death certificate be the attending physicied for use as the burined for use as	sic	1 Yes 2 No 9 Unknown g Unknown	eath 5 O	ther (Specify)			
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	ds, equire een si ould b	Completed				24a. Was a autops		autopsy findings available to completion of cause of
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	Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by the funeral director, page 2 should be detach		25. Was case referred to medical		26.Place of Dea	ath (Check only one)		
	Vita ysicia his cer direct	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien			Residence 6 🗸 O	ther: Scene
	of ng Ph	ᆵ	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Injury at W		ow injury occurred	
	ision of Vital Attending Physiciau: rr death. rector: After this certif by the funeral director,	atio	1 X Natural 5 Pending 2 Accident Investigation				treet and Number of	r Rural Route Number, City
	lor A after of Direct	Certification:	3 Suicide 6 Could not be determined (Specify)	nome, tarm, stre	eet, factory, office building	or Town, St		,
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10	Division of Vital Rec To the Hospital or Attending Physiciau: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Examiner: On the basis of examination	and/or investig	ation, in my opinion, death	h occurred at the time, date a	ind place, and due t	o the cause(s)
٢	No. of With	Mec	and manner stated. 29b. Signature and title of certifier		29c. License num	ber	29d. Date signed	
4			Mayorie Dre Yhill.		O.C.M.E.		November 1,	2008
	8		30. Name and address of person who completed cause of death (Ite			NAD 04004		
	70		Margarita Korell MD. Assistant Medical Exami		Penn Street, Baltim	ore, MD 21201		
	S Regi:	State	10007117 4 71 71111V 1 2014 - 4	K Los	de			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician NOVEMBER DE **JOSHUA** S SOLOMON 2008 6:28 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/330/1919 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 043-07-7545 CT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE, #109 USA Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No If Yes, Give Year or Dates: Specify <u>۾</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER OFFICE EQUIPMENT 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) HARRY SOLOMON ANNA HALLEM ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 PARK HEIGHTS AVE, #109, BALTIMORE, MD 21215 MIRIAM SOLOMON / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 11/07/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS CONTESTAR NEPORT PAILLIFE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC KLONEY DISEASE 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown CORONARY ARTERN OISCASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □ Yes 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \(\) \(\) Other (Specify) 1∐Yes 2∭No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be execu

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or iten Important: If item Z7 is marked other than "natural", or iten May hjury or other traumatic event, I'm Madical Ewinin ance.

Physician

/Medical

Examiner

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attending physician for use as the buria

signed by the a

Exami

Physician/Medical

Completed

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Certification: To

Medical

29a. Certifier

(Check only one)

Maryland 21215-0036

2008

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Division of Vital Records, P.O. Box 68760, Solomon Jushina Hospital or Attending

this certificate has al director, page 2 s after death Director: , d in by the f within 24 hours aft

To the Funeral Di

completely filled in To the Within 2

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

NOVEMBER 6.2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MA 6565 NCHARLES ST, SMITE 209 32. Registrar's Signature

EALTIMOPE, MS 21204

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or important or other traumatic event, Its. Modical Evantiant outs bennone. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

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law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the 1 filled in by

P.O. Box 68760,

Division of Vital Records,

Physician/Medical 2 Completed Be

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DHMH 17 Rev 1/2001

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9^k□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MOORE HARLES E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ING CROSS ROADS #102 CATONSVILLE, MD21228 M.D. 32. Registrar's Signature

31. Date filed (Month, Day, Year)

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UNK UNK		Please Type or Print in Black State of Maryland / D	k inde epartn	nent of Health	and Ment	opies Ar al Hygien	e Legii e	2008	3561
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Physicia Medical Exami	411/	Michael Roy Terry, Sr.					th Death ember 3,	ay Year , 2008	3. Time of Death 1859 hrs
The state of the s		Facility Name (if not institution, give street and number) University Hospital		4b. City, Tov Baltimo	vn, or Location of	f Death		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last bi	irthday) If Under	1 Year If Under		,	MM/DD/YYYY) 9. Birth	
Director		212-70-3710 1 ^X M 2 F 50)	Yrs. Months	Days Hours	Min. No	v. 11		ntry) MD
any			. City, Tow	n or Location					10d. Inside City Limits
yland ••f show	tor	MD Baltimore		10f. Zip C	Lansdowr	ne	100	Citizen of What Coun	1 Yes 2 X No
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	I Director	4210 Hollins Ferry Road			21227		J	United Sta	tes
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72 hour n "natu al Exan	ᄝᅵ	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	ed) 16a	 Decedent's Usual Or during most of working 			ie 116	6b. Kind of Business/Ir	dustry
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MD 21 rd 2 should I th and Mer m 27 is man	ပ	19a. Informant's Name/Relationship (Type, Print) Michael Terry, Jr.	1					er, City or Town, State, ${\sf Highlands}$,	
re, W 1 and 2 F Health If item 2				e of Disposition (Name atory or other place)		Date		20c. Location - City or	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examina	owledge, d	eath occurred at the ti		ce, and due to	the cause(s	s) and manner as state	d.
To with To I	Med	and manner stated. 29b. Signature and title of certifier			icense number			9d. Date signed (Mon	
		Mayona The Youll			D.C.M.E.		١	November 4, 200	8
1		 Name and address of person who completed cause of death Margarita Korell MD. Assistant Medical Exa 	, ,) 111 Penn Stree	et, Baltimore	, MD 21201			
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	Look)					
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Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and

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Certification:

Medical

State Registrar

1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ D	OA Other: 4 Nursing	Home 5 Residence	6 □Other (Specify)
27. Manner of Death Natural 5 Pending a Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, factor fy)	y, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
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29b. Signature and little of certifier	Maj	-AV)29	c. License number 039(1 2 29d. Da	tte signed (Month, Day, Year) 7 20
30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Print)	Baltin	use mod	21224
31. Date filed (Month, Day, Year) NOV 1 0 2	32. Sgistrar's Signa	the Specie	,		(

10:04AM

9. Birthplace (State or Foreign

10d, Inside City Limits

Approximate Interval Between Onset and Death

~200

Year

Day

Probably 4 ☐Unknown

... Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Month

X □ Yes 2 □ No

Virginia

		1	For State of Maryland State Registrar		rtment of H			jiene 🕕 🖟 eg. No.)8	356	21
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Year	3. Time of D	eath
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	mine	•	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Death			
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Mental Hygiene.		Re	17. Father's Name (First, Middle, Last)			18. Mother's Name			ne)		
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			For State Registrar	State of Mai	•	epartment of F Certificate of			leg. No 2008	35622
	Physicia	an	1. Decedent's Name (First, Middle, Last Dorothy	Anna		Weiss		2. Date of Dea November		3. Time of Death 4:00 a M
40	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of De	ath
	Funeral		6441 Cloister Ga 5. Social Security Number 6. Se 203-12-2929 1	7. Age	(In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	N/A (Year) 9. B	hirthplace (State or Foreign Country)
	Director		Usual Residence of Decedent					JUCT 17,	1924 Pe	ennsylvania
	Marylar II.ed st	tor	MD 10b. County N/A		10c. City, Town Baltimo					1 XYes 2 No
	with the a or 28s	Director	10e. Street and Number			10f. Zip Code 21 21 8		1	I0g. Citizen of What C	Country?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantine must be rutilled at once.	Funeral	3801 Canterbury F 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces?		13. Was Decedent of H If Yes, specify Cub	tispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		nerican Indian, iite, etc.
Maryland 21215-0036	ural", or	þ	3 ☑ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 □ No	Specify:	-		nite
215-	hin 72 h e. an "nati	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Busines	-
d 21	filed wit Hygien ther th		12 17. Father's Name (First, Middle, Last)		Hc Hc	memaker	18. Mother's Name	e (First, Middle,	Own Home Maiden Surname)	3
/lan	uld be Mental arked o	To Be	John Kish				Dorothy	Kakey		
Mary	d 2 sho th and th small trauma		19a. Informant's Name/Relationship (7) Patricia L. Nichol		1 .	Mailing Address (Street +1 Cloister				
Jore,	ages 1 an nt of Heal : If item 2		20a. Method of Disposition 1 ☐ Burial 2 又 Cremation 3 ☐	Removal from State	20h Place of	Disposition (Name of crematory or other plants of Service Co		Date	20c. Location - City o	or Town, State
Baltimore,	permit. Pa Departmen mportant iny Injury		4 □ Donation 5 □ Other (Specify 21. Signature of Furteral Service Lisens			22. Name, and Addre RUCK TOW 1050 Yor	i			-
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to	he death. Do no					Approximate Interval Between
a,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. lung	cance					Onset and Death 2 years
	Examiner		Sequentially list conditions,	b	consequence o					3
	uted X ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	f):				
68760,	ficate be executed physician and streets the burial-transit		resulting in death) Last	Due to (or as a	consequence o	f):				
Box 68	leath certifical attending phy for use as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		3 ☐ Ectopic pregnance	CV		23d. Date of d	•
.O. B	t the deat by the atte ached for	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at t		5 Other (specify)			Month	Day Year
rds, F	w requires that the d been signed by the should be detached	۵	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause given	ven in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
Reco	The law re te has bee age 2 shoi	Completed						24a. Was a autop: perfor	sy prior t	
Vita	Physician: The la r this certificate ha ral director, page 2	Be C	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Deal	th (Check only or	ne)	
ot	ding Phys h. After this funeral dir	n: To	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day,	/ 28b. T	patient 3 DOA	ry at		ence 6 X Other (S) ow injury occurred	Daughter's Residence
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	1 Natural 5 Pending investigation 3 Suicide 4 Homicide Pending investigation determined		v - At home, far	· · · · ·	Yes 2□No	28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	(Check only 2 Medical Exam	ysician: To the best of iner: On the basis of	f my knowledge, examination and	, death occurred at the t	ime, date and place opinion, death occu	, and due to the or	cause(s) and manner date and place, and d	as stated.
	To the Newithin 24	Med	29b. Signature and title of certifier	and manner stat	<u>-</u>	29c. Licen:	se number		29d. Date signed (Mo	
	10		30 Name and address of person who				60203			7,2008
	12		Rosalyn Juerge 31. Date filed (Month, Day, Year)				hnsHopkir	W CRBI	-643 Bal	hmove, Maryle
	Sta Registr		131. Date filed (Month, Day, Tear)	2. Registra	J. A	porte				
D1.0	ALL 47 Day 4 (0	004			- CA					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 2, **Physician** 12:30 PM 2008 John F Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 514 Hawthorne Road Anne Arundel Linthicum Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number Sex 1AM 2□F 7. Age (In yrs. last birthday) **Funeral** Months Days 215-24-3857 79 Yrs. 8, Maryland 1928 Director Nov. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mexical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel MD Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 514 Hawthorne Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 X No 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. Ith and Mental Hygiene. 7 is marked other than "n. International Long Elementary/Secondary (0-12) College (1-4or 5+) Shoreman's Assoc. Time Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Richenburg Charles Williams 19a. Informant's Name/Relationship (Type. Print)
Mary A. Williams - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Hawthorne Road, Linthicum, MD 21090 permit. Pages 1 and 2 st Department of Health an Important; If item 27 is r any injury or other traun 20b. Place of Disposition (Name of Meadowr 102e or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 11-7-2008 Elkridge, MD □ Donation 5 □ Other (Specify) of Funeral Service Acensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 months Physician _0^ disease or condition resulting in death) /Medical Due to (or a va consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): physician s the burial P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached f 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar d title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Sigeature

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29b. Signature a

31. Date filed (Month, Day,

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Agnes /// Registrar's Signature 900 Caton Drewe Baltimere

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year CHARLES WHITE аМ November 07, 2008 10:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1625 SPENCE STREET MORRELL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 X M 2 □ F 212-20-4433 Director 82 Sept. 13,1926 Maryland Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It will disall Expressions must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f sl 1. Yes 2 □ No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1625 Spence Street 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 N/A Bricklayer Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Η. Mary ျှ Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. White (Son) 1111 Leonard Drive Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11/14/08 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, Maryland 21. Signature of Funeral Service Licensee McCully Polyniak Funeral Home, P.A. 237 East Patápsco Avenue Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months cane luha disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3
 Ectopic pregnancy ò in the past 12 mont Month Day Year 5 ☐ Other (specify) 9 Unknow After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) Manyfer of Death 28b. Time of 28d. Describe how injury occurred 1. Natural
2 Accident 5 Pending investigation 1 🗆 Yes 2 □ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number DOS7486 multipleted cause of path (Item 23a) (Types Printerness). Bours more Mo 21201. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Deau Pay Year Month Day Year 2008 Physician Eleanor Blanche Winkenwerder /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Roland Park Place Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 5, Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Days 99 MD Director 216-54-6474 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🗖 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3700 Belmont Ave. 21136 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Completed by Specify. 3 NWidowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Zouck Eleanor Nellie Dempwolf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 Belmont Ave., Reisterstown, MD 21136 Peter Winkenwerder Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 11/6/08 Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road w true Eline Funeral Home Reisterstown, Md. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death immediate Cause (Final disease or condition resulting in death) a therosclero to heart disease Physician ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy perform 1 ☐ Yes 2 ☐ No 1FT Yes 2 1 No ital or Attending Physician: T is after death.

ral Director: After this certificate led in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) injury 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Newher 6, 2008 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
NISPBEUT TREPREGIE, 930 W. 40 H. Street, Baltiniste, 7d 21211 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 0 2008 State Million De Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** GEORGE D. BREWER 31, 10:20 A M October 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F 213-20-1360 82 11/1/1925 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f sho 1 ☐ Yes 2X No Director MD Harford Street 10g. Citizen of What Country? 10e. Street and Number 301 Cherry Hill Road 21154 USA an "natural", or items 23a Medical Examiner must b Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥JYes 2□No IfYes, Give Year or Dates: ₩WII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 8 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Brewer Katherine Holley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Nastvogel/Daughter 301 Cherry Hill Road, Street, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Evans Eagle Crematory 11/1/2008 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Part1. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m rediate Cause (Final Isease or condition (acmin Physician resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) attending physician Completed by Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Day 4∐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

29d. Date signed (Month, Day, Year)

poer Chesapoal

(Check only one)

29b. Signature and title of certifier

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Beachy Marvin 24, 2008 October Fay 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 700 E. 16th St. Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Days Hours Year) Months 1**X** M 2□ F Maryland 67 March 24, 1941 Director 216-40-3331 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov r than "natural", or items 23a or 28a-f shorthe Modeal Examinations be notified at 1XYes 2 □ No Directo Frederick Frederick MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21701 Funeral 700 E. 16th St Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 1959-If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify ģ Specify. 3 Widowed 4 Divorced White Year or Dates: 1962 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Construction 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once. Be Bessie Gertrude Wilburn Vernon Clay Beachy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 700 E. 16th St., Frederick, MD Donna R. Beachy/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery Oct. 26, 2008 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 40 P.O. Box 275, Grantsville, MD JUL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he or failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastalk disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Be Completed by Physician/Medical director, page 2 s Certification: To

Physician /Medical **Examiner** law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760,

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician for use as the buria been signed by the a should be detached to has certificate within 24 hours after death.

To the Funeral Director: A completely filled in by the f

Hospital or Attending Physician: The

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 2 ☐
25. Was case referred to medical	26. Place of Deat	h (Check only one)
examiner? 1 ☐ Yes 2 ☐	Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Ho	ome 5 Residence 6 □ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day, Year) 28b. Time of light yers 2 □ No 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could no 4 Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

Registrar

Medical

10

29a. Certifier

29b. Signature and title of certifier

30 Name and address of p

501 West Seventh Street, Frederick, Maryland 21701 M.D. Elhamy Eskander, 31. Date filed (Month, Day, Year) 2 OCT 9 2008

32. Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

		1	For State Registrar	State of Ma	arylan		artmen <i>rtificat</i>			d Mer		ene g. No. 🤈	n n s	3 35631
	siciar edica	1	Decedent's Name (First, Middle, Last) MEYER		BOBRO)W					Date of Death Month CTOBER		2008	3. Time of Death 512 A M
	mine		4a. Facility Name (If not institution, give 11203 Potomac Cres	t Drive				Town, or	Location of De	eath			inty of Deatl	
Fune Direc			311-24-3123	7. Ag	e (In yrs. i 84	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in. M	Date of Birth (Month, Day, [ay 8,	Yea <i>r)</i> 1924	Co	nplace (State or Foreign untry) and
Maryland -f show	INC. AL	ľ	Usual Residence of Decedent 10a. State 10b. County MD Montgome	ry	10c. City	y, Town or Loc Potoma								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the		DI DI G	10e. Street and Number 11203 Potomac Cres	st Drive	<u> </u>		10f, Zip	Code 0854			10	•	of What Coo	•
15-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show	Action of the Party of the Part	3	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 MYes 2 □ I If Yes, Give Year or Dates:	No.	l l	1	dent of Hi cify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify erto Rica	Yes or No- an, etc.)	14. F		rican Indian, , etc.
within ene.	Completed	nuibleten	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5	i+)	16a. Deced (Give life. L	lent's Usua kind of woi OO NOT us Owne	rk done d se retired,	urina most of v	vorking	1		f Business/I	·
yland 2 vuld be filed v Mental Hygi arked other	To Bo	ם ב	17. Father's Name (First, Middle, Last) Isaac Bobrow			L			18. Mother's N	,				
re, Maryland 2 s 1 and 2 should be filed if Health and Mental Hyg then 27 is marked othe			19a. Informant's Name/Relationship (Ty, Stanley V. Beckern	pe. Print) Power an - Atto	r of orney	19b. Mailin			nd Number or Street	Rural Ro	oute Number,			ip Code)
more, M Pages 1 and 2 ent of Health nt: If item 27	5 6	Ī	20a. Method of Disposition 1X Burial 2 □ Cremation 3 X R 4 □ Donation 5 □ Other (Specify)	emoval from State		lace of Disposemetery, crem				Date 0/28			on - City or T	own, State
Baltimord permit. Pages 1 Department of the important: If ite	once.		21. Signature of Funeral Service License	90	_	Da	. Name an .nzans	d Addres	s of Facility Foldber ville P	g Me	morial	Chap	els I	nc
Physici /Medic	cal		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each lir	ne. Conge a consequ	n. Do not ente	er the mod	t Fa	g, such as card	diac or re	spiratory arres	st,		Approximate Interval Between Onset and Death 6 Months
68 / 60, rtificate be executed to physician and as the burial-transit	i i	Ical Evalling	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ierice of).	oraci	c Ga	rdiovas	scula	ir Dise	ase	-	0 Years
death certified attending	M'nei	y sicial miss	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic p Other (sp					1	Date of deli Month	very Day Year
_ <u> </u>	À	ה ביילים מיילים	Part II. Other significant conditions con	tributing to death bu	ut not resu	ılting in the un	derlying ca	ause give	n in Part I.					the cause of death?
The The ate h	2		OF Was again referred to modifical								24a. Was an autopsy performe	ed?	prior to c death?	topsy findings available ompletion of cause of
T VIII nysicia nis cert directe	G G		25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 ☐ Inpatie	ent 2 🔲 I	ER/Outpatien	t 3 🗆 DO	Otho	26. Place of D r: 4 ☐ Nursing		<i>heck only one)</i> 5 X Residen		Other (Spec	rify)
Afte fune	Certification: To		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28a. Date of Inju (Month, Day	ry v, Year)	28b. Time of Injury	M 2	8c. Injury Work 1 □ Y	at ? ′es 2 □ No	28d.	Describe how	injury occ	curred	
를 하를 들	Certifi		4 Homicide determined	28e. Place of Injubulding, etc.							City or Town,	State)		ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Diruction Completely filled in 1	Medical		29a. Certifier Certifying Phys	ician: To the best of er: On the basis of and manner sta	t examınat	wledge, death tion and/or inv	estigation,	, in my op	inion, death of	ace, and ccurred a	due to the car it the time, dat	use(s) and te and plac	d manner as ce, and due	stated. to the cause(s)
25	2		29b. Signature and title of deruner	100/	rD			License	number 0 5 6 3	79	290			Day, Year)
			80. Name and address of person Wro co Robert Marshall MD					700	Chevy (Chase	e MD 20	815		
	State	1	31. Date filed (Month, Day, Year) OCT 2.7 2008	2. Registra	ar's Signat	ure	At a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2008 Mary Elizabeth Bissett OCT. 24. 4:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min 1 M 2 F Hours 83 1925Washington, DC 579-20-8380 Ĵan. 16, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 □Yes 2 No Director Maryland Prince George's Laurel death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6601 McCahill Terrace 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 []Yes 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 [] Yes 2 [X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Harry Whibley Frances Underwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Oakes, Daughter 6601 McCahill Terrace, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 MRemoval from State 2008 Fairfax Memorial Pk. 4 Donation 5 Dother (Specify) Fairfax, Virginia 22. Name and Address of Facility
Fairfax Memorial Funeral Home 21. Signature of Funeral Service Licensee The M01508 9902 Braddock Road, Fairfax, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine requires that the death certificate be executed ACUTE BRAINSTEM CVA and Due to (or as a consequence of): burial P.O. Box 68760, physician Physician/Medical **SEPSIS** the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð DEMENTIA 1 Tes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒ No 24a. Was an has page 2 autopsy certificate 2XINo 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP Mychilu D0064760 OCTOBER 24, 2008

Registrar

State

MYTHILY VANCHA, M.D., 7300 VAN DUSEN ROAD, LAUREL, MD 20702

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 2 7 2008

Amend #11, per Inf G886 12/4/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Robert Dalisay Baquir October 23. 2008 1:56 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7828 Somerset Court Greenbelt Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F 213-84-2642 62 9, 1946 Philippines Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Mcdical Examination units or million at 1 ☐ Yes 2 Tx No Director Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7828 Somerset Court 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ SpecifAs ian 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor Baquir Rosita Dalisay ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristina Calalang/Daughter 9520 Ament Street, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov. Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarct ; /Medical Due to (or as a consequence of) Examiner Chronic Renal Failure Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2XXVo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🙀 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, certificate e Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica 2 To the 1 within 2 To the 1

certificate be executed

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Baltimore, Maryland 21215-0036

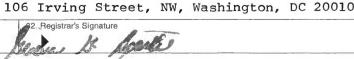
State Registrar

31. Date filed (Month, Day, Year)

Ocuin, MD

Jay

29b. Signature and title of certific



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D21955

29d. Date signed (Month, Day, Year)

October 25, 2008

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

BAID State

Registrar

31. Date filed (Month, Day,

614 B 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

SHORE DR, SALISBURY MD 21804

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al er	4a. Facility Name (n, give						or Location of D		Ī		y of Death	
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	5. Social Security N		6. Se	ex	7. Age (Ir			If Under 1 Year			of Birth	no rl	9. Birth	place (State or For
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<u>ĕ</u>	10e. Street and Nu			,		C)		10f. Zip Code			10g	. Citizen of	What Cou	intry?
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Funeral Director	11. Marital Status			12. Was Dec		in U.S.	13.	Was Decedent of	Hispanic Origin	? (Specify Yes	or No-	14. Ra	ce - Amer	ican Indian,
ᆵᅵ	1 Never Marr	ied 27 Mar	ried	Armed Fo	2 🗌 No			If Yes, specify Cul		uerto Hican, e	tc.)	Bla	ack, White,	, etc.
হ	3 Widowed			If Yes, G Year or [ive			1 □ Yes 2 🖺 No	Specify:			Speci	ify: Wh:	ite
<u>8</u>		15. Deceder	nt's Edu	ucation			16a. Dece	dent's Usual Occu	upation		16	b. Kind of E	Business/Ir	ndustry
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Completed	Elementary/Seco	лкцату (0-12)		College (1-401 0+)		Truck	Driver				Trans	port	ation
Be C	17. Father's Name	(First, Middle,	, Last)						18. Mother's	Name (First, i	Middle, Ma	iden Surna	me)	
To B	Herbert .	John Cl	hall	ker, Si	r.				Margue	rite N	afus			
F	19a. Informant's N						19b. Mailii	ng Address (Stree				City or Town	n, State. Zi	ip Code)
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- 1	20a. Method of Dis		LC I	, ,,,,,,,	2			sition (Name of matory or other pla		Date		c. Location		
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	4 ☐ Donation			<u>, </u>		Kest		en Cemet			1	igerst		
	21. Signature of Fu		_				- 1	2. Name and Add						-
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23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between	
	shock, or hea	art failure. List	r comp	olical that	caused the each line.	death.	Do not en	er the mode of dy		_		t,		Interval Between
	shock, or hea Immediate Cause	art failure. List (Final	r comp t only o	olical that	caused the each line.	death.				rdiac or respira		1,		Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** CONKLIN ROBERT WILLIAM 10:00 P M OCTOBER 20 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month Day, Nov 30, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **₩** M 2□ F Ohĭő 284-16-5743 86 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show 1 √Yes 2 No Director Frederick |MD|Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 USA 3023 Sanctuary Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Ves 2 □ No If Yes, Give Year or Dates: 1942-48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 📈No "natural", or Specify: White <u>۾</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Food Service Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zelma Ivalo Watkins Charles Gordon Conklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3023 Sanctuary Lane Frederick, MD 21701 19a. Informant's Name/Relationship (Type. Print) Rose M. Conklin/wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 10/24/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE LUNG DISEASE CHRONIC Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 □ No Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by DISEASE 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No CHRON 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After t Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

2 State Registrar

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Florin Rusu, M.D. 400 W. 7th Street Frederick, MD 21701

31. Date filed (Month, Day, Year) OCT 24 2008

29b. Signature and title of certifier

32. Registrar's Signature MELARI

29c. License number

29d. Date signed (Month, Day, Year)

8005115101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08176 State of Maryland / Department of Health and Mental Hygiene Sonia Lynn Marie Corbin Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3 Time of Deat 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2008 Year 1026 hrs Marie Corbin Sonia Lynn Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham **Doctors Community Hospital** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Funeral Foreign Months Days Hours Min Dec.20,1977Waghington,Dt Director 30 2 X F 220-11-4167 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ob. County 10a State 1 Yes 2 X No Waldorf Charles 28a-f shov rector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number notified at U. S. A. 20602 1006 Stone Avenue $\bar{\Box}$ 238 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) × Married Armed Forces Never Married 2 Yes 2 X No specify: White Yes 2 X No specify: hours after Divorced If Yes. Give Yeer 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 d other than " Lowe's Home Center MD 21215-0036 Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Marie Weaver marked æ Leon Soroka of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Constitution Ave. NE, Washington, DC20002 Father Leon Soroka / 20c. Location - City or Town, State Date If item ? 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, November crematory or other place) Burial 2 X Cremation 3 6,2008 Alexandria, VA Metropolitan Cr. Donation 5 Other Specify 22. Name and Address of Facility Raymond Funl. Service, P.A. 21 Signature of Funeral Service 5635 Washington Ave., La Plata, MD20646 M00641 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death **Medical** Methadone and alprazolam intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a, PII, 27, 28a-f, perm, E g886 12/4/08 Physician/Medical X UNPENDED ysician burial Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE phy: the b Year Dav 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown ⋧ Epilepsy 24b. Were autopsy findings available Completed Records, 24a. Was an prior to completion of cause of autopsy performed? death? has s certificate has rector, page 2 sh ✓ Yes No Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Division of Vital Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 27. Manner of Death After Certification: Yes 2X No Natural Fnd 10/31/08 Fnd 942 hrs Pending To the Funeral Director: completely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8118 Good Luck Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 8 Could not be 3 Suicide Doctors Community Hospital Lanham, determined Homicide

Registra

within 24

Medical

29a. Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

NUV

1 2 30. Name and address of person who completed cause of death (Item-23a)

2008

all

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 1, 2008

State of Maryland / Department of Health and Mental Hygiene 35637 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 24, 2:20 aM October 2008 /Medical M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Wheaton Silver Spring
If Under 1 Year | If Under 24 Hi Montgomery 8. Date of Birth (Month, Day, Year)
May 21, 19 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🛣 F 216-22-1580 92 Director Texas Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 11769 Veirs Mill Road 23a 20902 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status be filed within 72 hours after de ntal Hygiene... d other than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ≥ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 'n Beautician Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be a Health and Menta em 27 is marked Unknown Humphreys ပ Lela Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie E. Baum/Daughter 11769 Veirs Mill Road, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 24 Oct. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W, Silver Spring MD 20001 that the mode of dving, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed Cerebrovascular Accident Due to (or as a consequence of) Box 68760 Physician/Medical Atherosclerotic Cardiovascular Disease the attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Rectal Carcinoma, Congestive Heart Failure, Hyperlipide ia 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 X Natural 5 Pending investigation death. 1 □Yes 2 □No Director; 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) D47865 October 24, 2008 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers Oney Zuniga, MD 4701 Randolph Road, #216, Rockville, MD 20852 31. Date filed (Month, Day, Year) egistrar's Signature State 27 Registrar CCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AMEND#7 per FH, 10/27/08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 6:50 am Ying-Hwa Chang October 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springbrook Adventist Silver Spring Montgomery 7. Age (In yrs last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number Funeral Days 1 ☑ M 2 ☐ F July 7, Director China 578-78-0491 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Exerciser must be nullified at 1 ☐Yes 2 X No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 10801 Wheeler Drive U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gardener Self Employed marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H ' is marked oth Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Unknown ഉ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10801 Wheeler Drive, Silver Spring, MD 20901 Leah McIntyre - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/24/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a nonsequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit DEMENT resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached fo 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 ☐ Yes 2 No certificate 2 🗆 No : After this certification and a funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Ki Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

P.0. Division of Vital Records,

ne Hospital or Attending P n 24 hours after death. The Funeral Director: After to pletely filled in by the funera within 24

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

S. M. NAYAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE

D-17874

29d. Date signed (Month, Day, Year)

COTTAGE CITY ND 20722

Darian D'Iron Cole 08-07938

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Deat Decedent's Name (First, Middle,Last) Physician/ Month Day October 22, 2008 0245 hrs DARIAN D'Juan Cole **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 6/30/71 Director 37 213-08-9604 \mathbf{X}_{M} Cheverly,MD 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ì 1 X Yes 2 No Washington DC , or items 23a or 28a-f show r must be notified at once. Director 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number 20019 USA 6222 Clay Street, N.E. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death 1
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item Armed Forces? 1 X Never Married Yes Specify: Black If Yes, Give Year Yes 2 X No specify: Widowed Divorced marked other than "natural", ic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) Private Industry Maintenance Technician 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Cole Bruce L. Dodson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 425 2nd Street, N.W., Washington, DC 20001 Sharon Cole/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) XBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/01/08 Suitland, MD Donation 5 Other Specify 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee Depart Impor injury 3821 - 14th Street, N.W., Wash., DC 2001 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi executed hysician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify, 5 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> \$ Yes 2 V No 3 Probably 4 Unknown Completed Records, has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 certificate page 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Residence 6 DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 this 1 Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject shot 1 FOUND: Yes 2 V No Natural Pending 24 hours after death. I Director: Oct 21, 2008 2143 hrs Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) 6200 Clay St. NE, Washington, DC determined (Specify) Alley 4 V Homicide To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 October 22, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day Year) 32. Registrar's Situature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of L		_	giene Reg. No. 2	08 35640			
		_	Decedent's Name (First, Middle, Las	†)				2. Date of De Month	ath Day	3. Time of Death			
	ysicia Vedic	_	FLORENCE	MARGARI	ET, CRO	CKEN		OCTOBE	2 20 2	5002 11:00 bw			
	amine		la. Facility Name (If not institution, give			7	Location of Death		4c. County	of Death			
) 			HARBOR HOS 5. Social Security Number 6. Se	PITAL	(In yrs. last birthday)	BALTI If Under 1 Year		8. Date of Bir	th	Birthplace (State or Foreign			
Fun Dire	eral ctor	ľ		□M 27 F 8		Months Days	Hours Min.	Dec. 1	0,1922	9. Birthplace (State or Foreign Country) Maryland			
D C	and the same of th	-	Usual Residence of Decedent		10c. City, Town or Lo	postion				10d. Inside City Limits			
arylar show	dat	.	MD 10b. County Anne Ar	undel	Pasader					1 ☐ Yes 2 ☑No			
the M 28a-f	otifie	Director	10e. Street and Number			10f. Zip Code		T	10g. Citizen of W	/hat Country?			
with 3a or	t be		112 Spruce Aven	ue		2112	22		USA				
death	L	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race	e - American Indian, k, White, etc.			
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show	event, the Medical Eximiner must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give	0	1 □ Yes 2 汉 No	Specify:	•	Specify.				
Z15-UU36 thin 72 hours af e. an "natural", or	al Ex	ed by	3 Widowed 4 □ Divorced	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	siness/Industry			
72 nin 72 an "na	Medic	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	de completed) College (1-4or 5-	(Give	kind of work done of DO NOT use retired	ation during most of work d)	ing					
o filed within 7 st Hygiene.	the	E I	12		<u> </u>	Homemak			Home				
Yland Jiahd Jiahd Mental Hy arked oth	event	Be	17. Father's Name (First, Middle, Last) Robert Butterwo	~th			18. Mother's Name	et Dutr		e)			
YIA		卢	19a. Informant's Name/Relationship (7		19h Maili	nn Address (Street				State. Zin Code)			
Mar nd 2 sh lth and 27 is m	or other traumatic		Sandra L. William	s/granddau	ighter 80	34 Pine	and Number or Rur Ridge Roa	d Pasac	lena, MD	21122			
re, IV s 1 and of Health item 27	other	ŀ	20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce) Oct	Date 2.4	20c. Location -	City or Town, State			
altimore, rmit. Pages 1 a partment of Hee portant: If Item	iry or		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		MD Vetera		ATT UCL.	08	Crowns	ville, MD			
Baltimo permit. Page Department of	any Inju once.		21. Signature of Funeral Service Licen	see	B:	2. Name and Addre	Sons, P.	A. Seve	erna Parl	k Funeral Home k, MD 21146			
£ .	0	_	23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between			
Physic	cian	1	Immediate Cause (Final disease or condition	a RESPIR		FAILURI				Onset and Death			
/Med	U. 353.06		resulting in death)	Due to (or as a		3							
Exam	iner	_	Sequentially list conditions,	b. RENAL		UNKWOUN							
Ited	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CONGE		HEART	FAILU	12.IT		UNKNOWN			
J, execu	ial-tra	ш	resulting in death) Last		a consequence of):	(1 ()	11110	140		0,114,00			
68760, ficate be executed the sician and	ne bur	edical		d									
	e as th	Med	IF FEMALE:										
Geath certice attending	for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	□Ectopic pregnanc	у		23d. Dat	le of delivery nth Day Year			
. 0 0	tached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	inic or dodin								
	be deta	by Ph	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?			
ords equire	should b							1 🗆	Yes 2 1 Mo	3 Probably 4 □Unknown			
Records, he law requires to has been signed.	2 sho	Completed						24a. Was	psy i	Were autopsy findings available prior to completion of cause of			
	I director, page 2 s	Con						pert 1⊟ Yes	ormed? 2 No	death? 1 □ Yes 2 □ No			
Vital iclan: T	ector	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dear		,				
Vision or Vital Attending Physician: r death.	eral di	2	1 Yes 2 No	28a. Date of Injur		SIL SU DOA	4 LI Nursing H		idence 6 Oth how injury occur				
ion (nding F th.		tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		rk?]Yes 2 □ No						
Division or lor Attending Phy after death.	by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju- building, etc	ury - At home, farm, si	treet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Div	filled in												
DIVISION To the Hospital or Attention 24 hours after death	etely fil	Medical	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	nysician: To the best on niner: On the basis of and manner sta	examination and/or i	ith occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and ma e, date and place,	anner as stated. and due to the cause(s)			
To the	completely	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, Day, Year)			
			I kuione ku	d Almei	da.	RES	001		OCTOBER	2,20,2008			
111	e/		30. Name and address of person who		_		11 A	0 ===	~ ^ 1 -	0.02			
(At	Sta	te	31. Date filed (Month, Day, Year)	DE AL	MEIOA ar's Signature	5001 S	HANOVE	K ST	BALTIN	iore, MD			
R	عاد egistıا		OCT 2 3 2			book							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 24 2008 1:00 a Bob E. Carter, Sr. October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 63 Woodcrest Drive Elkton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours 232-50-5658 73 January 19,1935 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Elkton MD Cecil 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 21921 **USA** 63 Woodcrest Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status "natural", or item edical Examiner r Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: þ White 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Service Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hassel T. Carter, Sr. Ruby Saunders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 Woodcrest Drive., Elkton, MD 21921 Cristina Galasso/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Met/lod of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rising Sun, MD **Brookview Cemetery** October 28, 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MeTASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to acco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an CONAVI autopsy page PRIPHERAL 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be No. Hospital: Other: 4 \sum Nursing Home 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) P 27. Manner of beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

death certificate be executed Box 68760. physician P.0. signed by to Division or Vital Records, been has certificate this After t Hospital or Attendl 24 hours after death. Funeral Director; A death. filled in by the

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

within 24 hours at To the Funeral D

5 State Registrar

Medical

0 ims 31. Date filed (Month, Day,

29b. Signature and title of certifie

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Downell M.D

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Peoples Plata Newall

32. Registrar's Signature 2008

			For State of Maryland		rtment of F tificate of I			/	2008	35642
			Registrar 1. Decedent's Name (First, Middle, Last)		incate or i	2. Date of Dea			3. Time of Death	
	Physici /Medic		Robert Estill I			Octobe	r 31	2008	0742 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number)	r Location of Death			ounty of Deat	h		
and the	Funeral		Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. le	ast birthday)	E1kton	If Under 24 Hrs.	8. Date of Birt (Month, Da		Cecil 9. Birtl	hplace (State or Foreign
ı	Director		_236-18-3058 ¹¼™ ²□ F 87	Yrs.	Months Days	Hours Min.	NOV 13	y, Year) , 1921	0Wes^{c_0}	t Virginia
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Loc	ation					10d. Inside City Limits
	Maryl a-f sho	ţoţ	Maryland Cecil E1	kton						1∭Yes 2□No
	th the	Director	10e. Street and Number	REOH	10f. Zip Code			10g. Citize	n of What Co	untry?
	s 23a	erall	229 Milhollan Drive		21921				ited St	
(0	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, its Madical Expraire must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 1 □ Never Married 4 □ Dispersed 1 □ Widewood 4 □ Dispersed	d 13. W		lispanic Origin? (Spe an, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, White	
036	ours al ral", or Excert	Š	3 ☐ Widowed 4 ☐ Divorced If Yes, Give War	II 1	□Yes 2∏XNo	Specify:		Si	pecify: Wh	iite
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup	during most of working	ng .		of Business/	-
72	within iene. than	omo	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired Chinist	i)			comobil ufactu	e Wheel
þ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,			11 1118
ylar	should be and Mental s marked o	10	William C. Davis			Kate Sny	der			
Mar	12 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)	1	-	and Number or Rura		-		ip Code)
Б	t and Health tem 27		Gemma Z. Davis/Wife 20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name of	Drive, E	ate		21921 ition - City or T	Fown, State
9E	Pages nent of ant: If ite ury or o	Ш	1 🕅 Burial 2 □ Cremation 3 □ Removal from State Imm 4 □ Donation 5 □ Other (Specify)	metery crem lacuTat letery	e Concep	tion Nover	nber 008	Ch	erry F	ill, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Madical Expression must be notified at once.		21. Signature of Funeral Service Licensee		Name and Addres	ss of Facility for Fune:			icity ii	TIII, IID
Ш	20 E # 9		Gusten Hicks Risman	10	<u> 3 W. Sto</u>	<u>ckton Stre</u>	eet, El	<u>kton,</u>	MD 2	1921
			23a. Part 1. Soter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final	(3		ng, such as cardiac of	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to for as alconseque		ncer					
****	Examiner		I Endst	12	COPI					
	ed sit	iner	Sequentially list conditions, if my leading to increase the cause. Enter Underlying Cause (Disease or injury	ce of):						
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68760,	ifficate be executed g physician and as the burial-transit	edical	d							
	ertifica ling ph e as th		IF FEMALE:							
Box	death certific e attending p ed for use as f	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	déath 3 🗌	Ectopic pregnancy Other (specify)	y		230	d. Date of deli Month	very Day Year
О	0 0 0	hysi	1 Yes 2 No 4 Pregnant at time of de 9 Unknown 9 Unknown	au 50	Other (specify) _					
	requires that the	by P	Part II. Other significant conditions contributing to death but not result	ting in the une	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
Records,	w requir been si should I						1 X Y	es 2 🗍	No 3∏ Pro	obably 4 Unknown
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Vital	sician: The law certificate has b irector, page 2 sl		25. Was case referred to medical			OC Disease Death	1 □Yes	2 No	1 ☐ Yes	2/No
	> .º 0 I	To Be	examiner? 1 ☐ Yes 25 No Hospital: 1 Inpatient 2 ☐ E	R/Outpatient	3 □ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hon]Other <i>(Sp</i> ec	cify)
Division of	ng Ifte		27. Marner of Death DENatural	28b. Time of Injury	28c. Injury Work	y at 2	8d. Describe h			
SIO	Attending or death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hon	na form atra		Yes 2□No	Of Logation (C	·	Vision from a Co	- LD- vt- North-
<u>^</u>	al or A after I Direct d in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)	le, iailii, sire	et, lactory, office		City or Tow		vumber or Au	ral Route Number,
			29a. Certifier (Check only (Ch	ledge, death	occurred at the tir	ne, date and place, a pinion, death occurre	and due to the	cause(s) ar	nd manner as	stated.
	o the lithin 24	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License				gned (Mon	
	F ≯ F ŏ		Kola 5	vin	DO	05641	49	10	31/	08
		Ì	30 Name and address of person who completed cause of death (Item	23a) (Type, P	'rint)	101	200	F-1		11.00 (7:00
			31. Date filed (Month, Day, Year) 32. Registrar Signatu	11 W.	High S	t. Duite	302	411	Tar	MD 2192
	Stat Registra		NOV 1 0 2008	france)	ş l					
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DHMH 17 Rev 1/2001

		For State Registrar		State	of Ma	arylan		artment of F rtificate of i			-	gien Reg. N	7111	38	35643
Physic	ian	1. Decedent's Nam								2. Date of De		ŽĨ, 2008		3. Time of Death	
/Medi Exami	cal	Helen M				4b. City, Town, or	OCLODE		c. County o		9:00 P M				
LAGIII		11926 Qu		ceet			Fulton					oward			
Funeral Director		5. Social Security N	e (In yrs. I. 67	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da)ct I,	194	1	9. Birth Cou Rho	place (State or Foreign atry) Le Island			
yland now		Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	cation						1	10d. Inside City Limits
e Mar	ctor	MD	Howard	Fult	on							1 □ Yes 2 → No			
with the	Dire	10e. Street and Nur 11926 Qu		r eet				10f. Zip Code 20759				10g. Citizen of What C			ntry?
id Z IZ IS-UU30 filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or items 23a or 28a-f show ent, the Medical Evan in an unst be rediffed at	Funeral Director	11. Marital Status 1 □ Never Marri		12. Was De Armed 1 □ Yes	Forces? 2 PNN		1	Was Decedent of H	ispanic Or an, Mexica	rigin? (Spe n, Puerto f				- Ameri , White,	can Indian, etc.
5-UU36 72 hours aft natural", or	d by	3 🗌 Widowed		If Yes, (Year or				1∐Yes 2ÅNo	Specify:	:			Specify:	Whi	ite
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, Mar and 2 sho salth and n 27 Is m er traum		19a. Informant's Na Michele I	ame/Relations Kempf/c	hip <i>(Type. Print)</i> laughter			19b. Mailir 11926	ng Address <i>(Street o</i> Queen St	and Numb treet	er or Rura Fult	Route Numb	er, City 20	or Town, S 759	state, Zij	Code)
partimore, Maryland ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantian to use to rediffical anone.		20a. Method of Disposition 1 ☐ Burial 2 2 4 ☐ Donation	Cremation	3 □ Removal from	n State	l ce	emetery, cren	sition (Name of natory or other plac ce Cremato	e) ory		ate 4/08		ocation - C	-	
Definit. Departition of the control		21. Signature of Fu	ineral Service	Ligensee H	٩	MO		Name and Address ing Home							x 784 e. MD 21029
		23a. Part1. Enter the shock, or hea	he sease, or ort failure. List	complications that	t caused each lin	the death	. Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory a	rrest,	arres v	1110	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer 1 year											Onset and Death year		
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icate be executed physician and the burial-transit	edical			d											
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12, 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?		e birth gnant at	of pregnar 2 Fetal time of de	death 3 □	Ectopic pregnancy Other (specify)	/				23d. Date Mont		ery Day Year
uires that to signed by id be detact	by	Part II. Other signif	icant condition	ons contributing to	death bu	ıt not resul	ting in the ur	nderlying cause give	en in Part i						he cause of death?
law req as beer 2 shou	Completed									-	24a. Was	an	24b. W	ere auto	opsy findings available
The icate his page	Com										autor perfo 1 □ Yes	rmed?	de	ath?	mpletion of cause of 2 No
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ng Phy fter this		27. Manner of Death		28a. Dat		у	28b. Time of Injury	28c. Injury Work	at		ne 5 Resid 8d. Describe I				<i>y</i>)
r Attendi er death. rector; A	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6 Could r determ	not be 28e. Plac	e of Inju		ne, farm, stre		/es 2□		8f. Location (S	Street a	nd Number	or Rum	al Route Number,
pital o	1 1	29a, Certifier	10 Certifyin	1				occurred at the tin	an data a	ad place of			,		
the Hos in 24 ho the Fun ppletely	Medical	(Check only one)	2☐ Medical	Examiner: On the	basis of nner stat	examinati	on and/or inv	estigation, in my o	pinion, dea	ath occurre	ed at the time,	date an	d place, ar	nd due to	o the cause(s)
Vith Vith Com	Σ	29b. Signature and	title of certifier	dollar	/ L	u()		29c. License					ate signed		
000		30. Name and addre	ess of person	who completed car	use of de	eath (Item	23a) (Type, F	D38509					ober 2		
(3)00	10	Nicholas 31. Date filed (Mont				D. 1		ittle Pat	uxen	t Par	kway C	olun	nbia,	MD	21044
Sta Registr		_	OCT 2 4		27		A A	racks							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** DREMER FAYE SPENCER DOVE OCT. 16, 2008 7:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 □ M 2 □ MF 109-48-7690 47 Director Nov.10,1960 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, the Medical Exercitor is ust be notified at Director MD Montgomery 1 Yes 2 □ No Germantown with the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 18527 Nutmeg Place 20874 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Evantine and any Injury or other traumatic event, the Medical Evantine Apple. 1 ☐ Yes 2 If Yes, Give 1 XNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Kinder Care Elementary/Secondary (0-12) College (1-4or 5+) <u> Ţeacher</u> Learning Center yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Spencer ပ Florence Utley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Spencer (Brother, 12712 Ben Fry Drive, Chester, VA 23831 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Souls Cemetery 10/25/08 Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Lic 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failly re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke disease or condition resulting in death) l montn /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No signed by the a P.0. 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? Coaqulopatny page 2 autopsy certificate perform 1 □ Yes 2X No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1∐Yes 2√∑No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 X Natural 5 Pending the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) the within 7 nd title of certifier 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D28656 10/20/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Rd, #208, Rockville, MD 20850 Kavı Passi, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 27 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician OMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Chesapeake Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Director 214-56-9696 12/23/1949 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Modical Evandrar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Maryland Brook1vn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA 618 Washburn Ave. 2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give X 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No \$ Specify: White 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Press Operator Rock Tenn 11 18. Mother's Name (First, Middle, Maiden Surname) ies 1 and 2 should be file of Health and Mental H fitem 27 is marked oth 17. Father's Name (First, Middle, Last) Bertha Lee Sauers Issac Thomas Leroy Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Colesbury Pl. Jessup, MD. 20794 Amelia C. Griffiths/Sister permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/22/2008 Kalas Crematory Edgewater, Maryland 21. Signatur Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death

The Leve Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a c nsequence of) Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Exami burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) MOUSE 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. rsgn who completed cause of death (Item 23a) (Type, Print) FENSE HIGHWAY ANNAPOLIS MOLIYU) Name and address

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day, Year)

23

2008

32 Registrar's Signature

		•	For State Registr <i>a</i> r	State of Maryla		irtment of F <i>tificate of I</i>		Mental Hy	giene Reg. No. 2	008	35646
	Dhusisi	.	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		EVELYN	М. Е	NDERS			a de	- 22-	2008	6:41PM
The same	Examin		4a. Facility Name (If not institution, give str	reet and number)	1.	4b. City, Town, or	Location of Death	٦	4c. Coun	ity of Death	
-2			Coastal Hospic	Rat The L	ake	Salis b			U	icom	ico
	Funeral		5. Social Security Number 6. Sex	4 01/1	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ay, Year)	Countr	ace (State or Foreign ry)
	Director		213-34-8/14	71	Yrs.			FEB. 19	, 1937	MARY	ŹLAND
0	. A		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10-	d. Inside City Limits
Ann	fsh	ō	MARYLAND WORCESTE	7D	BERLIN	•					1 X Yes 2□No
4	289	Director	10e. Street and Number	arc	DEKLIN	10f. Zip Code			10g. Citizen o	f What Countr	·v?
Arith	3a ol	0	326 WILLIAMS STRE	ET		218	11		US	٨	
+000	ms 2	Funeral		Was Decedent Ever in I	J.S. 13. V	Vas Decedent of H		pecify Yes or No		ace - America	
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9500-	Exit	t by	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates:		∐ Yes 241 No	Specify:		Spec	city: WHI'	ΓE
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	and Mental Hygie is marked other t	٩	19a. Informant's Name/Relationship (Type		405 84-115-	- A dalaca - (Cha A	SUSI		JOHN		3- 1-1
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ָב נֿ <u>ק</u>	Heal Heal tem 2		20a. Method of Disposition		Place of Dispos	ILLIAMS :	1	Date Date		n - City or Tow	
	ayes ent of tr. If it		1 XBurial 2 ☐ Cremation 3 ☐ Ren	moval from State	cemetery, cren	natory or other plac		/27/08	RERT	IN, MAF	ONA TV
	artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wire Funeral Service Licensee		NDEN OF 22	THE PINE CEMETER	s of Facility	27700	DEKE.	in, riai	KILAND
	portion; ages, that and should be partment of Health and Menta Important; If them 27 is marked any injury or other traumatic evonce.		1//////////////////////////////////////	A. A		ASTINGS 1		HOME, SE	LBYVIL	LE, DE.	. 19975
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√ PI	hysician		shock, or heart failure. List only one immediate ause (Final				77	0.00			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	MALIGNA Due to (or as a conse	quence of):	BLADD	1265	4126	INOU	7	
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Ď	ling p e as	Mec	IF FEMALE:								
ath Ge	uttenc or us	Physician/M	23b. Was decedent pregnant in the past 12 menths?	i. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3 □	Ectopic pregnanc	/			Date of deliver Month E	y Day Year
. e	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify)					
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	ificate or, pa	o C e	25. Was case referred to medical					1 ☐ Yes	96 No	1 □ Yes 2	2 ANO
V Sicia	s cert lirectc	80	examiner?	spital: 1 ☐ Inpatient 2 ☐	TER/Outpotion	Othe	26. Place of Dea				11.03
2 9	ar this	٦.	27. Mapner of Death	28a. Date of Injury	28b. Time of	28c. Injur	4 🗀 Nursing H	ome 5 Resi	how injury occi		Hospice
	th. : Afte	ţ	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Ďay, Year)	Injury		? Yes 2 □ No				
Attending	r dea ector by th	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I	ome, farm, stre	et, factory, office		28f. Location (Street and Nur	nber or Rural	Route Number,
5 2	s afte	Certification:	4 nomicide	building, etc. (Spec	lly)			City or 10	wn, State)		Į.
ospit	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			cian: To the best of my kn r: On the basis of examin							
He H	nin 24 the F uplete	Medical	one)	and manner stated.	ation and/or m	T	pilloli, death occi	THEO AT THE TIME.	uate and place	s, and due to	une cause(s)
2	To To	Σ	29b. Signature and title of certifier	~		29c. Licens			29d. Date sign	,	1-
	200		10			200	05841	0	10,	1231	108
	C MAIL		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type, I	Print)	21 1		4.6	7	mp 21802
			31 Date filed (Month Day Year)	32 Registrar's Sign	105P	1ch	, V 1/30P	1733 5	Acust	2mil	mo 21802
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of Hortificate of L			giene Reg. No. () (38	35647
	Physici /Medic		1. Decedent's Name (First, Middle,	(ast)	idle	1		2. Date of De Month Octobe	Day	2 0 0 8	3. Time of Death 10:45P M
	Examir			Nursing Home	e rrs. last birthday)	4b. City, Town, or Baltimo			4c. County	y of Death	
L	Funeral Director		094-16-3447 Usual Residence of Decedent	1□M 2ØF	88 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Aug. 16	y, Year) 5,1920	Ohio	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland 11 of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic evant, the Medical Examinar must be notified at	Director	10a. State 10b. County Maryland 10e. Street and Number		City, Town or Lo				10g. Citizen of		10d. Inside City Limits Y Yes 2 □ No
	3e or		3310 Benson Av	enue AptG		21228			U.S.A		•
36	s after death , or Items 2: aminer mus	by Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1	n U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 XNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	14. Ra	ce - Americ ick, White, fy: Wh:	etc.
21215-0036	hin 72 hour 8. 8n "natural" Medical Ex	Completed b	3X Widowed 4 □ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Dates: Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor.	king	16b. Kind of B		
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Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r raumatic evant, the Med	ae S	17. Father's Name (First, Middle, La Salvatore Brar			1	18. Mother's Nan Sarah (ne)	
lan.	and and is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	ng Address (Street a	nd Number or Ru	ral Route Numb	er, City or Town	, State, Zip	Code)
Baltimore, N	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra ance.		Scott Fridley 20a. Method of Disposition XXBurial 2 Cremation 3	208	b. Place of Dispo		1	Date	20c. Location	- City or To	land21228 own, State s, NewYork
Baltir	permit. P Departme Importan any injuri 9000		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		22	2. Name and Addres	s of Facility Ma:	rzullo	Funera	al Cl	hapel,P.A. yland21214
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition		eath. Do not ent	ter the mode of dying	, such as cardiac	or respiratory a	rrest,	71141	Approximate Interval Between Onset and Death
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	e Hos 24 ho e Fun etely i	Medicai	(Check only 2 Medical Ex	Physician: To the best of my learning: On the basis of examiner: and manner stated.	ination and/or in	n occurred at the tim- vestigation, in my op	e, date and place inion, death occu	rred at the time,	date and place,	and due to	o the cause(s)
)	To the Hospital within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier	CRIP		29c. License	number 615		29d. Date signe		
		l 3	30. Name and address of person when the state of the stat	io completed cause of death (I	Item 23a) (Type,	Print) h CRLP	3320 Bal	De Ber			21227
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0 200	32. Registrar's Sig	gnature						•

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			For	State of Ma	ryland .				Mentai Hy	giene	∌ ∩∩8	35648
		_	 State Registrar 			Cei	tificate of	Death	F	Reg. No		000.0
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	/Medic		A. Facility Name (If not institution, give	e street and number)	<u> </u>	, ,	4b City Town o	Location of Deat	h	4c.	County of Death	0-7-
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			JUI 1417 (1) 1 1 10	MOLICI F	(In yrs last		If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h	Julie	and (State of Foreign
	Funeral		5. Social Security Number 6. S	TVM 2DE	(III yis iasi	Yrs.	Months Days	Hours Min.	(Month, Da)	y, Year)	Coun	ace (State or Foreign try)
	Director		564-44-8//9	81		, , , ,			April 2	2 1	92/ Swit	zerland
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				11	Od. Inside City Limits
	show	7										1⊕Yes 2□No
	N 90 N	ctc	MD Garret	<u> </u>	Uak	1and						
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Coun	try?
	72 hours efter death with the Maryland neturel; or items 23s or 28s-f show diest Exardisermust be notified at	- a	109 N. Scott Str	eet			21550				ited Stat	es
	eg E E	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-		14. Race - Americ Black, White,	
ဖွ	or it	F	1 Never Married 2 Marned	1 ☐ Yes 2 ☑ No)	1	Yes 2X No	Specify:			Specify:	
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21:	within 7 ene. then "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	OO NOT use retired	d)	g			
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	Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden	Sumame)	
an	d be ental ked c	ToB	unknown					Jeanne	Froi	deva	aux	
2	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, Ita Ma	1	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	a Address (Street	and Number or Re	ural Route Numbe	er. City o	or Town, State, Zip	Code)
Maryland	d 2 s th ar th ar treu treu		Christine Froid	- 1011							n, Switze	
	1 and Health em 27 ther tr		20a. Method of Disposition	evaux, Daug			sition (Name of	5 11221.	Date		ocation - City or To	
Baltimore,	v + = 0		1 Burial 2 XCremation 3	Removal from State	cem	etery, crer	natory or other place					
Ξ.	Part and ury	ļ	4 Donation 5 Other (Speci	(y)	Cumb	erla	nd Cremat	ory 10/	31/08	Cui	mberland,	MD
a	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Lice	nsee ,		22	Name and Addre	ss of Facility Burdock	Funeral	Ho	me. P.A.	
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	Physician /Medical		disease or condition resulting in death)	a	v en	Tr C	(0(1	7 ()			in	45-WE21-7
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	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	100 01).						
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760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to (or as a	consequen	ice or):						
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99	death certificate I attending physi	Physician/Medi	15.55.141.5									
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٦	thet det	y P	Part II Other significant conditions	contributing to death but	not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco	use contribute to th	e cause of death?
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	The peg	Ö	Acute 1/es	, Vein	11	ala.	- has	15	1 ☐ Yes	rmed?	death? 1 ☐ Yes	2□ No
<u>=</u>	itan: artific ctor,	Be	25. Was case referred to medical examiner?		•		· · · · · · · · · · · · · · · · · · ·	26. Place of De	ath (Check only o	ne)		
*	Physician: this certific ral director,	Ţ	1 ☐ Yes 2 No	Hospital: Unpation	t 2□ER	VOutpatier	t 3 DOA Oth	er: 4 Nursing H	Home 5 ☐ Resid	dence	6 ☐Other (Specify	v)
	g Pr er th eral	Ë	27. Manner of Death	28a. Date of Injury (Month, Day	Vaar) 28	Bb. Time of	28c. injur Wor	y at	28d. Describe I	now inju	iry occurred	
Ö	th.: Aft	읉	1 Aatural 5 Pending 2 Accident investigation		1021)	Injury		Yes 2 □ No				
is.	Attended by the	floa	3 ☐ Suicide 6 ☐ Could not b	286. Place of Injur	y - At home	e, farm, str	eet, factory, office		28f. Location (S	Street ar	nd Number or Rura	l Route Number,
Division	Dir	Certification:	4 Homicide	building, etc.	(Specify)				City or Tov	vn, State	θ)	
	To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, pege 2 should be de		29a. Certifier 1 Certifying P	hysicien: To the best of	my knowle	dge dest	occurred at the fir	me, date and place	e, and due to the	causers	and manner as s	tated.
	Hoy Fur	Medical	(Check only 2 Medical Exa	miner: On the basis of e	examination	and/or in	vestigation, in my o	pinion, death occi	urred at the time,	date an	d place, and due to	the cause(s)
	thin the	Me	29b. Signature and title of certifier	and mainer state	- 41		29c Licens	se number		29d. Da	ate signed (Month,	Day, Year)
	5 7 8 H		123	1: 1		MAG	2 //	6431	52	10/	27/08	,,
			10000	-ing hav		100	11		0	10/	4 (100	
		Λ	30 Name and address of person who	completed cause of de-	ath (Item 23	3а) (Туре,						
		4	Laniel H	Duckin	914	m	255 N	Fourth	St., Oak	lan	d, MD 215	50
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	Signatur	0	1 00					
				0 2000 M								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 22, 10:40 P October 2008 Bernard Floam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🕱 M 2 🗆 F 07/26/1920 Maryland 88 Director 216-05-9028 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland | Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20815 4620 North Park Avenue #1402W IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Retail 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental William R. Floam Jenny Shakewitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 14904 Dufief Drive, Gaithersburg, Maryland 20878 Ann F. Schlossenberg, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 10/26/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign for of National Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland Capatin 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Multiorgan Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of The law requires that the death certificate be executed Sepsis and burial-tra Due to (or as a consequence of): physician Physician/Medical Acute Stroke the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 I Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypercarbic Respiratory Insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐Yes 2 🛣 No Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

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Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

DHMH 17 Rev 1/2001

ORIGINAL

Dr Sirak Hagos Lemma, 1500 Forest Glen Road, Silver Spring, Maryland

D65069

mn

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

October 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Lemue1 James tober 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death lata 00 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 15, 7. Age (In yrs. last birthday, 9. Birthplace Country) (State or Foreign ^{Year)} 1938 1 M 2 □ F 178-30-4464 70 PA Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Charles LaPlata 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8431 Penns Hill Rd. 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No 3 ☐ Widowed 4 K Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secret Service Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Grant Fry Margaret Dixon Fry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Aurora Dr. Millersville, Md. 21108 19a. Informant's Name/Relationship (Type. Print) James Fry/Son 412 Aurora Dr. Millersville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 10/23/08 Charlotte Hall, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Arehart-Echols Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00945 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seplic Shoc Due to (or as a consequence of): pancrealie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last THE to for as a consequence of) obs Wach'u Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Tinknown 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 🗹 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

death.

24 hours after death Funeral Director:

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Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

death with the Maryland

21215-0036

land

Maryl

Baltimore,

Division of Vital Records, P.O. Box 68760,

burial-tran attending physician as the for use detached page 2 should has certificate director, this funeral After 1

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 1 No

29b. Signature and title of centifier

Date of Injury (Month, Day, Year) 5 Pending investigation

and manner stated.

28c. Injury at Work?

28b. Time of Injury 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6 ☐ Could not be

OCT 2 4

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year) 10110

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

4b. City, Town, or Location of Death

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and a	Physicia /Medic Examin	al	4a
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	Funeral Director		5. 5 Us
		-	Us
	e Marylar la-f show	ctor	10
	th with the 23a or 28 and be pro	al Dire	10
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its if hadical Exx. it is to main to or adjits of a once.	To Be Completed by Funeral Director	11
5-(72 h "natu	ete	
212	d within glene. er than	Somp	
yland	permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or its any injury or other traumatic event, Inc. Medical Exercise once.	To Be (17
Mar	nd 2 sho alth and 27 Is m r traum		19
nore,	ages 1 al		20
Baltimore, Maryland 21215-0036	permit. P Departme Importan any injuri		21

Anne Arundel Medical Annapolis Anne Arundel Center Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Months Days 61 77-64-1392 5-13-47 ual Residence of Decedent 10c. City, Town or Location 10b. County a. State Springdale MD. P.G. e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20774 3603 Cara Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Myes 2 No If Yes, Give Year or Dates: 1966 - 70 1 Never Married 2 Married 1 ☐Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fed. Gov't Dir. of Public Tran. '. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gloria Washington Ralph W. Ferguson, Sr. 9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3603 Cara Drive, Springdale, Md. 20774 Diane A. Ferguson/Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Mem. Park | 11/1/08 Landover, Maryland 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signatur Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Nackin Immediate Cause (Final disease or condition resulting in death) M20Voch Samac Due to (or as a consequence of): Due to (or as a consequence of) Examine

William Ferguson, Jr.

Physician /Medical Examiner

physician and the burial-transit

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been signed by the should be detached

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate or completely filled in by the funeral director, page

Physician/Medical

2

Completed

Be

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Certification:

Medical

The law requires that the death certificate be executed

P.O. Box 68760

of Vital Records,

G-Division

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 Unknown

IF FEMALE:

Ralph

Facility Name (If not institution, give street and number)

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4 ☐ Pregnant at time of death 9 Unknown

Due to (or as a consequence of)

3 🔲 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23,

2008

4c. County of Death

4:30 PM

D.C.

1XYes 2 ☐ No

10d. Inside City Limits

Birthplace (State or Foreign Country)

Wash.

14. Race - American Indian.

Specify: Black

Oct.

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably → Dunknown 24a. Was an autopsy 1 ☐ Yes 2 300

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ##

25. Was case referred to medical examiner? 1 | Yes 2 | → Yes

5 Pending investigation

6 Could not be

Hospital: 1 I topatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature a

30. Name and

29a. Certifies

27. Manner of Death

1 Accident

3 ☐ Suicide

4 ☐ Homicide

1 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majner stated. DM35494

29d. Date signed (Month, Day, Year) 10/23/2008 2001 | Medical Pkyy Anhapolis M

Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year, 7 OCT



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 0ct 25 2008 1:45 P^M Gordon Priscilla /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Oakland Garrett Dennett Road Manor Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 KF Director 578-14-9035 May 5, Maryland 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ist. Pagea 1 and 2 should be filed within 72 hours after death with the Marylar arment of Heath and Mental Hyglana portent; If tem 23a or 28e-1 ehow portent; If tem 27 is marked other then "neturel", or Iteme 23a or 28e-1 ehow in Injury or other fraumatic event, the Medical Examinar must be notified as injury or other fraumatic event, the Medical Examinar must be notified as 1 ☐ Yes 2 ☐ No Director Garrett 0akland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 United States 1113 Mary Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 1 Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Murray Sophia (unknown) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 457, Colonial Beach, VA Odessa Henderson, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery 10/29/2008 Oakland. MD permit.
Departr
Importe
eny Inju 22. Name and Address of Facility
David A. Burdock Funeral Home 21. Signature of Funeral Service Licenses 21 N. Second St., Oakland, MD atherine weeks Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** wen /Medical Tue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ Ho 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 Yes 22 No 1 Tes 2 -NO After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funerel Director: After the completaly filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 28b. Time of Certification; 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ヲ th (Item 23a) (Type, Print) 30. Name and address of terson who completed cause of dea Sotiere Savopoulos, MD 255 N Fourth St., Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Directo

Funeral

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Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

Funeral

Director

or 28a-f show

or items 23a

2 should be filed within 72 hours after on and Mental Hygiene.

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

Physician

/Medical Examiner

nding physician

The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

3altimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

death with the Maryland

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10c. City. Town or Location

7. Age (In vrs. last birthday)

97

Rea. No. 2 Date of Death

5:00 p M

October 18, 2008 4c. County of Death

Griffis 4a. Facility Name (If not institution, give street and number) Springvale Terrace Assisted Living

4b. City, Town, or Location of Death Silver Spring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Montgomery

5. Social Security Number 6. Sex 1 □ M 25 F 170-10-8660

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Months Days

14, Aug.

 Birthplace (State or Foreign Country) 1911 Pennsylvania

10d. Inside City Limits

Usual Residence of Decedent 10a. State 10b. County

Montgomerv

Silver Spring

1XYes 2 No

Maryland 10e. Street and Number

8505 Springvale Road, #21

20910

10f. Zip Code

16a. Decedent's Usual Occupation

10g. Citizen of What Country? IISA

12. Was Decedent Ever in U.S

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

Federal Government

1 ☐ Never Married 2 ☐ Married 3√ Widowed 4 Divorced

Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

1 ☐ Yes 2 TNo Specify:

Secretary

Specify: White 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

(Give kind of work done during most of working life. DO NOT use retired)

Completed 17. Father's Name (First, Middle, Last) Be

18. Mother's Name (First, Middle, Maiden Surname)

Andrew Sysak

19a. Informant's Name/Relationship (Type. Print)

Justina Opryshka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Marjorie Cano/Niece

20b. Place of Disposition (Name of cemetery, crematory or other place)

1061 1st Avenue, Apt. 4B, New York, NY 10022 Date 20c. Location - City or Town, State

20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

Fort Lincoln Cemetery

Oct. 2 2008 Brentwood, Maryland

21. Signature of Funeral Service Ligensee Nichard Z Hates

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

Acute	Cere	brova	scul	ar	Accid	len:
Due to (or as	a conseq	uence of):				

Due to (or as a consequence of):

Due to (or as a consequence of):

23d. Date of delivery

resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy

5 ☐ Other (specify)

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

Chronic Obstructive Pulmonary Disease

Hospital:

24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

Year

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 🗆 No

Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ \bigcirc Other (Specify) Assisted 28d. Describe how injury occurred

26. Place of Death (Check only one)

Living

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barbara F. Burkett, DO 11000 New Hampshire Ave., Silver Spring, MD 20904

H0045523 October 24, 2008

State Registrar

31. Date filed (Month, Day, Year)

27 2008 Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

within 24 hours a To the

Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica

funeral director,

filled in by

1 Natural 2 Accident

3 ☐ Suicide 4 Homicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. of Vital Records, Division To the Hospital or within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

e. Name and address of person wheteven Kariya,

29b. Signature and title of certifier



and manner stated.

of completed cause of death (Item 23a) (Type, Print) MD 10605 Concord St. #500 Kensington, MD 20895

29c. License number

D36252

29d. Date signed (Month, Day, Year)

October 15, 2008

			For	State of	of Marylan			lealth and l	Mental Hy	giene	000	35655
			- State Registra AMEND#8perFH		MW,McCo	Cei	tificate of	Death			008	
	Physicia	an	1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Gloria Watson G					Landan of Door	Octobe		2008 nty of Death	9:00A ^M
	Examin	er	4a. Facility Name (If not institution,		umber)		,	r Location of Death	1		•	
			Holy Cross Hos 5. Social Security Number	spital 6. Sex	7. Age (In yrs.	last hirthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Bir		1tgome 9. Birthi	place (State or Foreign
	Funeral Director		343-26-3167	1 □ M 2 💢 F	77	Yrs.	Months Days	Hours Min.	(Month, Da	th ly, Year <u>1</u> 93	Coui	ntry) inois
			Usual Residence of Decedent						Whiti.	2000		
	yland yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	10d. Inside City Limits
	Mar a-fsl	ctor	MD Montgo	merv	Si	lver S	oring					1 X Yes 2 No
	h the	Director	10e. Street and Number		112		10f. Zip Code			10g. Citizen o	of What Coul	ntry?
	th wil		2100 Washingto	n Avenue	#10-c		20910			United	l Stat	es
	within 72 hours after death with the Maryland lene. Itan "natural", or Items 23a or 28a-f show Ita Madical Eviminar must be notified at	Funeral	11. Marital Status	Armed F	cedent Ever in U. orces?	.S. 13.	Nas Decedent of H f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.))- 14. F	Race - Ameri Black, White,	
36	or It	by Fi	1 ☐ Never Married 2 ☐ Marri	I If Yes, G	2 X No		1 ∐Yes 2 📉 No	Specify:		Spec	cify:	1
9200-91212	hours ural"		3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:	160 Doco	dent's Usual Occup	aation		 16b. Kind of	Bla	
ς Δ	"nat	Completed	15. Decedent (Specify only highes	t grade completed,		I (Give	kind of work done DO NOT use retire	during most of wor	king		Basinosani	iddow y
71.	withi iene. thar	E O	Elementary/Secondary (0-12)	_	(1-4or 5+)	Teac	her			Educ	eation	
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Maryland	ld be lenta ked ic ev	To B	Augustus Dart	Watson				Eva L	ucille :	Scanlor	ı Wats	on
ar Ş	shou ind M imar	-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number or Ri				
ž	is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene and the state of the s		David C. Adams	Husband	l	6405	Rock Fore	est Drive	#301 B	ethesda	.Mary	1and 20817
e,	of He of He item		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Locatio	n - City or To	own, State
Ē	Page nent int: If iry o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Fr Fr		Union Ce		28/2008			
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service	see /		7	Name and Addre	ess of Facility Mc	Guire F	uneral West	Servi	ce,Inc.
m	89728	. 19	Synne".	men	ire	W.	ashingtor	.Distric	t of Co	lumbia		
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	17.40.40.40.40		ratory	Arrest					Onset and Death
	/Medical		resulting in death)	Due to	iorespi (oras a consec	uence of):	CALL COL					
	Examiner	L	Sequentially list conditions.	b. Left	Leg Ce	llulit	is					42*
	pe sit	Examiner	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events	Ctue fo	(or as 8 consec	mence of):						
>	and I-tran	хаш	that initiated events resulting in death) Last	c. Due to	o (or as a consec	mence of):						
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387	icate phys s the	dical		d								
×	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, o	utcome of pregn	ancy				23d.	Date of deliv	very
. Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?		e birth 2 Feta gnant at time of		☐ Ectopic pregnan ☐ Other (specify) _	су			Month	Day Year
o	the de	ysi	1 □ Yes 2 □ No 9 □ Unknown	9 □ Uni	known							
o.	s that the ned by t detach	by Pi	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
rds	w requires to been signer should be								1 🗆	Yes 2 □ No	o 3□ Pro	bably 4 X Unknown
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Ä	The lav te has age 2 :	E	<u> </u>							ormed? 2 🔯 No	death?	2 No
ā	sician; The la certificate ha irector, page?	BeC	25. Was case referred to medical					26. Place of De	ath (Check only			
>	Physician; this certific al director,		examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 X	Inpatient 2] ER/Outpatie	nt 3 ☐ DOA Oti	her: 4 🗆 Nursing I	Home 5 ☐ Res	idence 6 🗀	Other (Spec	rify)
Division of Vital Records,	ding Ph h. After th funeral	Ë	27. Manner of Death 1 XNatural 5 ☐ Pending	/4.4	e of Injury onth, Day, Year)	28b. Time o Injury	f 28c. Inju Wo	ıry at rk?	28d. Describe	how injury occ	curred	
<u> </u>	endii eath. or: A the fu	äţi	2 ☐ Accident investig	ation		===	M 1 []Yes 2□No				
ž	l or Attend after death Director:	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	nod Zoe. Flac	ce of Injury - At h ding, etc. <i>(Sp</i> ec	iome, farm, str ify)	eet, factory, office		28f. Location City or To	(Street and Nu wn, State)	ımber or Rui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it					- 1-1 1	h h h		The second street of the			stated
	Hosp 14 hor Fune Fely fi	Medical	29a. Certifier 1 Check only 2 Medical one)	g Physician: To the Examiner: On the	ne best of my kn basis of examin Inner stated.	owiedge, deat ation and/or ir	n occurred at the to restigation, in my	opinion, death occ	e, and due to thuring arred at the time	e cause(s) and , date and plac	ce, and due	to the cause(s)
	thin 2	Med	29b. Signature and title of certifier	and ma	. ^		29c. Licen	se number		29d. Date sig	gned (Month	, Day, Year)
		_	I VIV	10UM	ex mo							
,	20		30. Name and address of person	who completed as	se of death (Ita	m 23a) (Typo	D635	1 2		Octobe	:1 40,	2000
			Maria J. Tayag					Silver Sp	ring Ma	ryland	20910	
	Sta	ite	31. Date filed (Month, Day, Year)	\$2.	Registrar's Sign	ature 🥒	- M		, ,			
	Regist		OCT 27 2	2008	Juse B	190						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GEORGINA OCT. 22 C. GIMOTEA 2008 11:35P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville MONTGOMERY 8. Date of Birth (Month, Day, Year)
Feb. 22, 1935 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Months Days 215-53-3539 73 Philippines Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director ty Yes 2 □ No MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or 3 filed within 72 hours after death with 710 Anderson Avenue 20850 U.S.A. Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married jo. Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: Filipino þ 3 ☐ Widowed 4 ☐ Divorced 'naturai'', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Magruder Grocery College (1-4or 5+) Elementary/Secondary (0-12) Food Clerk yrs Store permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julian Canillas Adoracion Segovia 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Anderson Ave., Rae Pearl Canizares (Daughter) Rockville,MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Ardent Crematory 10/24/08 Hanover, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Litansee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cholangitis Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off law requires that the death certificate be executed Exami sician and burial-trans Hypertension Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Year Day 5 Other (specify) P.0. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 8 ₹ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1∐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the telety filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 63748 Ichou, J-Koul 10/23/08 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd, Rockville,MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#10bperFH, 10/27/08, BWW, MoCo 3565 Certificate of Death 2. Date of Death 3. Time of Death Month **Physician** Claudia Μ. Gail 7:38 P^M 21, Oct. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year 6-13-37 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2√2 F 71 424-48-8633 Ala. Director Usual Residence of Decedent 10b. County Montgomery 10c. City, Town or Location 10d. Inside City Limits 10a. State show ed other than "natural", or items 23a or 28a-f show 1 XYes 2 □ No Director MD. Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4301 Sarasota Place 20705 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, It. 11 Elementary/Secondary (0-12) College (1-4or 5+) N.L.R.B. Auditor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta Epps Joseph Sims ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Sarasota Pl. Silver Spring, Md. 20705 Roberta Gail/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition **X**Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/08 Maryland Nat. Cem. Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
The House of Williams F.S. ames 814 Upshur Street, N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Encephalopathy /Medical Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (dras a runsequance of) certificate be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE use. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 5 ☐ Other (specify) P.0. detached signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate 2 **X**No **2X** No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

State

Registrar

31. Date filed (Month, Day, Year) OCT 27

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D66162

29d. Date signed (Month, Day, Year)

Oct. 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12 HA M GUTIERREZ ULIO 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MARY LAND MEDICHL UNIVERSITY OF CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth , (Month, Day, 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours **1X** M 2 □ F Months Days 262-91-0327 Director VICA TAQUA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Manifest As intrust he mailled at any injury or other traumatic event, It a Manifest As in the traumatic and once. 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 Mes 2 □ No Funeral Director MARYLAND WICOMICO 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country 2180 U.S. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Yes 2□No þ 3 Widowed 4 Divorced HISPANIC raquan Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2180 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 3 ☐ Removal from State 21. Sign sture of Funeral S 21801 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each ling. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) **Physician** CIRRHOSIS NENOWN /Medical Due to (or as a consequence of): Examiner UNKNOWN COHOL ABUS E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ∐Yes 2 □No the 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To completely filled in by the funeral 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

BALTIMORE MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

PLOTNICK

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2008

DAVIEL

31. Date filed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Raymond Sohn Hartke 10 ລ 3 300g /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dummit Park CATONSVIlle Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 12M 2□F Days Hours 220-18-9509 84 Director 8-1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ ¥lo **Funeral Director** Md. Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? 3508 Rhode Valley Trail 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1944— If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ Specify: 3 Widowed 4 Divorced "natural", Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Auditor State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter H. Hartke Rose A. Miller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trau Doris K. Hartke/wife 3508 Rhode Valley Trail Ellicott City,Md. 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial 10/28/2008 Elkridge Md. 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licen-4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory irrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a fore quence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autops, performed: 2 No 2₩ No 101 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tes this (P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day mpletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. after death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated of cert (Da) 29b. Sigrature and title 29d. Date signed/(Month, Day,

State Registrar no

DHMH 17 Rev 1/2001

ORIGINAL

6 N. Kolling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato or wie	aryiana / L		tificate of L		Memarry	Reg. No.	008	35660
	Physici	an	1. Decedent's Name (First, Middle,	•					2. Date of De Month		Year-	3. Time of Death
	/Medic		4a. Facility Name (If not institution,	cah Sayyida I	shmael		4b. City, Town, or	Location of Deal			nty of Death	7700 M
-	LAAIIII		Prince Geo	: ./	ital		chev	erly		Pri	nce	Ceopers
	Funeral Director		217-23-1271	6. Sex 7. Age 1 □ M 2 ☑ F	e (In yrs. last bir 20	rthday) _ Yrs.	Months Days	If Under 2/4 Hrs Hours Min.		rth a <i>y, Year)</i>	9. Birthp	olace (State or Foreign ntry) ryland
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	0d. Inside City Limits
	Maryl a-f sho	tor	Maryland Cha	arles			Bryan	ns Road				1 □Yes 2 ☑ No
	ith the	Director	10e. Street and Number				10f. Zip Code	***		10g. Citizen	of What Cour	itry?
	eath w	Funeral	6824 Lantana I	Drive 12. Was Decedent B	Ever in II S	13 W	as Decedent of Hi	20616	Specify Ves or No) 14 F	U.S.A.	
39	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the "hydical Exanther; ust be nuffled at	by Fun	11. Marital Status1 ☑ Never Married 2 ☐ Marrie3 ☐ Widowed 4 ☐ Divorced	Armed Forces?			as Decedent of Hi Yes, specify Cubar □Yes 2⊠No		to Rican, etc.)		Black, White,	
2-0	72 hou	eted	15. Decedent's (Specify only highest	s Education crade completed)	16a	. Decede	ent's Usual Occupa	ation Juring most of wo	rkina	16b. Kind of	Business/In	
21215-0036	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use retired, Stude) -	9		Educat	ion
d 2	should be filed vand Mental Hygies marked other taumatic event, the	Be Co	17. Father's Name (First, Middle, L	ast)			Stude		me (First, Middle	, Maiden Surn		.1011
ylar	ould be Menta arked atic ev	To B		Jamaal Ishmael					Joy I	Easton		
Maryland			19a. Informant's Name/Relationsh			,	Address (Street a					Code)
	s 1 and 2 of Health item 27 other tr		Joy Easton - Mot 20a. Method of Disposition	her			Lantana Dri ition (Name of atory or other place		s Koad, Ma		20616 on - City or To	wn, State
altimore,	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Other (Sp		1		atory or other place ven Cemete	i i	27/2008	Silver	Spring,	Maryland
Balt	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service L	icensee		Hi	Name and Addres	Funeral			no Mars	71and 20904
			23a. Part 1. Enter the disease, or o	complications that caused	the death. Do						ing, mar	Approximate Interval Between
Star of	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Motor	Vehi	de	Accide	enturi	the Mu	etiole	Inju	Onset and Death
	/Medical Examiner		resulting in dealthy	Due to (or as	a consequence	of):				95		
	D #=	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence	of).						
)	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence	of)-						
68760,	rtificate be executed ng physician and as the burial-transit			d.		,-						
9		Medical	IF FEMALE:							- 1 -		
O. Box	The law requires that the death cer ate has been signed by the attendir age 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	,			Date of delive Month	ery Day Year
rds, P.	v requires that the de been signed by the should be detached	by	Part II. Other significant condition	ns contributing to death bu	ut not resulting in	n the und	derlying cause give	en in Part I.		tobacco use co		ne cause of death?
Records,	The law rec te has bee age 2 shou	Completed								psy ormed?	prior to co death?	psy findings available mpletion of cause of
Vita		Be C	25. Was case referred to medical examinar?						1 □Yes ath <i>(Check only c</i>		1 □Yes	2 LINO
	Physic this coral dire	၉	1 es 2 No		nt 2 ☐ ER/Ou	utpatient Time of		4 🗀 Nursing i	Home 5 ☐ Resi			
00	Jing J. After funer	tion	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigs		(, Year)	Inne or Injury のぞよ!	28c. Injury Work	rat ? ∕es 2 ☑No	28d. Describe	how injury occ	g cur	ed sail
Division of	l or Attend after death Director: J in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 280 Place of Init	iry - At home, fa		et, factory, office		28f. Location (City or To	Street and Nu wn State)		al Route Number
_	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	Medical C	29a. Certifier (Check only one) 1 CertifyIng 2 Medical E	p Physician: To the best of xaminer: On the basis of and manner sta	of my knowledge examination ar	e, death	occurred at the timestigation, in my or	pinion, death occ	e, and due to the	cause(s) and	manner as s	the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	11	7-		29c. License	number		29d. Date sig	ned (Month,	Day, Year)
	10		Harada	/flooder o	00		Hor	05597	27	Detob	w 23	, 2008
	u ^r		30. Name and address of person w	the completed cause of de	eath (Item 23a)	(Type, P	ital I	Drive,	char	ef,	MARY	Day, Year) , 20c P
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7	2008 32 Registra	ar's Signature	do	E)	,				

December Name (Pick Modes, Late) Committee Co			ı	For State	State of Marylan	· ·			211118	35661
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Double Personnel Superior of December 100. Clark Town of Contains 100. Clark Town of Contain						Months		8. Date of Birth (Month, Day, Yea	9. Birthptac Country	ce (State or Foreign
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The part of the pa		with the	Direc			10f. Zip 0	Code	10g. C	itizen of What Country	/?
The part of the pa		death me 23	neral		12. Was Decedent Ever in U	I.S. 13. Was Decede	ent of Hispanic Origin? (Specify Yes or No-		
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The part of the pa	2-0	72 hou natura	eted		ducation	(Give kind of work	done during most of w	orking 16b.	Kind of Business/Indu	stry
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Month Neg. 8601 Veter and May Suite 204, Milesville, md 2(108) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		e de de								ne cause(s)
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DHMH 17 Rev 1/2001

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	Dharini		1. Decedent's Name (First, Middle, Li						2. Date of Dea Month		Vear	3. Time of Death
	Physicia /Medio		Jane Walker John	- 					10	/14/200		7:05 pm M
A. Carrier	Examin	er	4a. Facility Name (If not institution, given 7101 Bay Front D					Location of Death		4c. County Anne		ndel
	Funeral Director		282-18-8003	Sex 1 □ M 24 5 x F 7. Age	(In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12/18/	1920	9. Birthp Coul	olace (State or Foreign ontry) Ohio
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	cation				1	0d. Inside City Limits
	Mary L-f she fied a	tor	MD Anne Ar	undel	Ar	nap	olis					1 □ Yes 2 No
	h the or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Cour	ntry?
	23a c		7101 Bay Front D	R				1403		USA		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Examiner must be multified at	by Funeral	11. Marital Status 1 Never Married 2 Married 32 Widowed 4 Divorced	12. Was Decedent Exarmed Forces? 1 Tyes 21XNo If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba □Yes 🏋 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Blad Specifi	ck, White,	can Indian, etc. White
Maryland 21215-0036	nin 72 hc s. in "natul	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5+		(Give I	ent's Usual Occup kind of work done o OO NOT use retired	durina most of worki	ing	16b. Kind of B	usiness/In	dustry
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<u>N</u>	and 2 s ealth an n 27 is I		Joyce Elaine Sal		1						otate, zn	Code)
ē,	s 1 ar of Hea Item		20a. Method of Disposition		20b. Place of	Dispos	Sition (Name of patory or other place	_ ;	Date	60025 20c. Location -	City or To	own, State
Ē	Page nent d ant: If		1 ☐ Burial ※X Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		1	-	Cremator		/2008	Glen Bu	rnie	, MD
Baltimore,	permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lice	ensee	,		Name and Addres	ss of Facility Har Ave. An	desty F napolis			P.A.
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final	nplications that caused to one cause on each line	he death. Do n	not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of	of):	AVIVA	<u> </u>			z	VERAL
		7	Sequentially list conditions	b. Due to (or as a	CONSEQUENCE		men/	70			- 1	years.
	uted d ansit	Examiner	Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	,,,						
o,	icate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence o	of):						
68760	ate be	edical		d .			·					
9 ×	eath certific attending p for use as t	/Med	IF FEMALE:	23c. If yes, outcome o	f pregnancy					and De	to of dalice	
0	000	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death		Ectopic pregnancy Other (specify)	У			te of deliv	ery Day Year
rds, P.	w requires that the dibeen signed by the should be detached	<u>₹</u>	Part II. Other significant conditions	contributing to death but	not resulting in	the un	derlying cause give	en in Part I.	23e. Did to	2		he cause of death? bably 4 🗍 Unknown
Vital Records,	E 8 01 1	Completed							24a. Was a autop: perfor	sy med?	Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of
/Ita	sician: The la certificate ha rector, page 2	BeC	25. Was case referred to medical examiner?					26. Place of Death				Accistal
5	Physician: this certific ral director,		1 Yes 2 No		t 2 ER/Out	.		4 LI Nursing Ho			ner (Speci	M) [-77/3/29
פחס	ding h. After fune	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,		ime of njury	28c. Injun Work	y at (? Yes 2 □ No	28d. Describe h	ow injury occur	red	
Division	or Atter fter dea irector n by the	Certification: To	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	De Blace of Injur	y - At home, far (Specify)	m, stre			28f. Location (S City or Tow	itreet and Numb n, State)	per or Rura	al Route Number,
_	<u>a</u> ⊃ = = = = = = = = = = = = = = = = = =	ledical C		hysician: To the best of miner: On the basis of and manner state	examination and							
_	To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier	130 om	mo	7	29c. Licenso	number 0 295	7/ 1	29d. Date signe	d (Month,	Day, Year)
•	1300	رر	30 Name and address of person who	completed cause of dea	ath (Item 23a) (Type, F	Print)	20 Asi	150	HW	1	crofton
	Sta Registra	_	31. Date filed (Month, Day, Year) OCT 2 2	32. Registrar	's Signature	_	land a			,		- Staffmanned
			114 4 2	LUUU CANA	es so		DEALL!					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Per State Amend Item 8 per fh,g889,03/23/09dhb Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last)
Lillian Ar 2. Date of Death 3. Time of Death 1 Pay Kozlovsky Physician Anna 2008 1:58 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Bel Air Upper Chesapeake Medical Cent Harford If Under 1 Year | If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 93 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 □ M 2 K F Months 213-09-4976 05/09/1915 Director Usual Residence of Decedent 10b. County Harford 10c. City, Town or Location 10d. Inside City Limits Baltimore, Maryland 21215-0036 show Md. Forest Hill 1 ☐ Yes 2 No Examiner must be notified Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 1 Colgate Drive 21050 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No White 'natural', or Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within is marked other than College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item Z7 is marked any Injury or other traumatic ev once. Tucek Panuska Frank Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph F. Kane P.O. Box 25 Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/3/08 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jarretts ville, Md. 21. Signature of Funeral Service Licensee, Benjamen h Kurter Kurtz Funeral Home, P.A. PO Box 6 23a. Part1. Exper the disease, or complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** two weeks neumomi disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Loslovsky Lillian MRH M&0331748 Division or Vital Records, P.O. Box 68760. burial-trai Due to (or as a consequence of): physician pe Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 1 No Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) an

State Registrar

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

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31. Date filed (Month, Day, Year)

NOV 1 0

			For State	State of Maryland	-				21	108	35664
			Registrar 1. Decedent's Name (First, Middle, Last)		Cel	rtificate of I	Jeath ———	2. Date of Dea	Reg. No. —	700	3. Time of Death
Н	Physici		Florence Kern					Month	per 23	Year	
and the same	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De			y of Death	9:20a
لم			Washington Adve	entist Hospi	tal	Takoma	Park		Mon	tgome	rv
	Funeral		Social Security Number 6. Sex		ast birthday)	If Under 1 Year Months Days	If Under 24 H Hours M		h	9. Birthpl Coun	lace (State or Foreign
	Director		130-18-0884 Usual Residence of Decedent	83	Yrs.			2/22/1		VA.	
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				10	0d. Inside City Limits
	a-f st	ctor	MD P.G.	ggU	er Ma	arlboro					1 □Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	s 23a		8618 Monmouth Dr			20772			U.S.A		
	item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No	5. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Ra Bla	ce - America ck, White, e	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiliar roughly notified at	þ	3 Widowed 4 Delivorced	If Yes, Give Year or Dates:	1	□Yes 2 No	Specify:		Speci	Blac	:k
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an	uld be filed Mental Hygi arked other attc event,	To Be	James Bland					e Paige	maiden dama		
Maryland	2 should and Mer is marke aumatic	F	19a. Informant's Name/Relationship (Ty)	oe. Print)	19b. Mailin	g Address (Street		Rural Route Numbe	er, City or Town	, State, Zip	Code)
	127 mg		Michele Clark r	eice	8618	Monmout	h Dr	Hnner M	arl bo	δM Ω	20772
altimore,	les 1 al		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b, PI	ace of Dispos metery, cren	sition (Name of natory or other plac	e)	Upper M	20c. Location	- City or To	wn, State
E	t. Pages tment of tant: If it		4 □ Donation 5 □ Other (Specify)	Riv	erdal	e Crema	tory 1	11/1/08	River	dale,	МД
Ba	permit. Pages Department of Important: If ii any Injury or on once.		21. Sign ture of Funeral Service License	e visita)		. Name and Addres	1	Hodges a			
		_	23a. Part 1. Enter the disease, or compli	cations that caused the death				I Rd. Su		bM,E	Approximate
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o to	Physician: r this certific ral director, I	To B	examiner? 1 ☐ Yes 2 🔁 No	ospital: 1 ဩ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe)F.	Home 5 ☐ Resid		her (Specify)
_	Ing P	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occu	rred	
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Division	after after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify))	et, lactory, office		City or Tow	n, State)	ber or nurai	l Route Number,
_	ospita hours ineral ly filler		29a. Certifier 1 CertifyIng Phys	Iclan: To the best of my know	vledge, death	occurred at the tin	ne, date and pla	ace, and due to the	cause(s) and n	nanner as st	lated.
	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	er: On the basis of examinati and manner stated.	on and/or inv						
	Neith Con To To To To To To To To To To To To To	2	29b. Signature and title of certifier	AAA		29c. License	number		29d. Date sign	ed (Month, L	Jay, Year)
			- Cypros	MD	00 \ /= -	1 14	1750		UCIUB	tkd	4 2008
-			30. Name and address of person who con	mpleted cause of death (Item AKA 73254	23a) (Type, F	TING PA	A Vand	LY CAFE	PRELI	MAR	Y(AVA 2022
F	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure -		IN FUUT	11 AVOR	34 (32 20)	1411/1	INTOSOTO
	Registra	ar	NOV 1 0 2008	Bruside H.	Acoust.	3					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07915 State of Maryland / Department of Health and Mental Hygiene 35665 Daniel R. Keegon-McClenon Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 21, 2008 0754 hrs Daniel Keegan-McClenon Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Oxon Hill 7100 Oxon Hill Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** oreign Guatemala Days Months Hours Min Aug. 19, 1983 579-08-3001 Director 25 1X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County in 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Washington D.C. None death with the Maryland Director 10g. Citizen of What Country? 10e, Street and Number USA 20003 1119 South Carolina Ave., SE Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 X Never Married Native American 2X No Yes 1 X Yes 2 No specify: Guatemalan Pages 1 and 2 should be filed within 72 hours after or to Health and Mental Hygiene. Widowed Divorced If Yes, Give Year Specify other than "natural", þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 Retail Target 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia M. Keegan Robert McClenon If item 27 is marked traumatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1119 South Carolina Ave., SE., Wash., DC 20003 Robert McClenon/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia Columbia Gardens Cem Oct. 27,08 Donation 5 Other Specify 'n 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral & rvice Licenses 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death 'Medical a. Intraoral shotgun wound Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical attending physician a UNPENDED AMENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown the detached 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown signed ģ Completed 24b. Were autopsy findings available 24a Was an peen prior to completion of cause of autopsy has death? performed? 1 1 No Yes 2 No Yes 2 this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other; Residence 6 V Other: Scene FR/Outpatient 3 Nursing Home 5 Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject shot self Certification: FOUND: Natural Yes 2 V No Director: Pendina 24 hours after death. Funeral Director: Oct 21, 2008 0615 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 7100 oxon hill, oxonhill, MD determined (Specify) Field Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: To the

OCME

29d. Date signed (Month, Day, Year)

October 21, 2008

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registra

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item-23a)

Assistant Medical Examiner

32. Registrar's Signature

			for State Registrar	State of Ma	ryland /		rtment of F tificate of			giene	38	35666
	Physici	an	1. Decedent's Name (First, Middle, Last,					· -	2. Date of Dea Month	Day	Year	3. Time of Death
and the same	/Medic Examin	al	Elsie Loui: 4a. Facility Name (If not institution, give		kingbil	1	4b City Town o	r Location of Dear	Novembe	r 1	2008	7:25A ^M
	Examin	ei	Northampton Manor		Center		Fred	derick			ederi	ick
	Funeral Director		5. Social Security Number 6. Sec. 1 4 - 14 - 6909	7. Age M 2⊠F	(In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) , 1915	9. Birthpl Count Mary	lace (State or Foreign try) land
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation				10	Od. Inside City Limits
	a-f sh	ctor	Maryland Freder	ick		١	Voodsbord					1 ☐ Yes 2 X No
	with the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W		•
	Jeath v	Funeral	9631 Gravel Hil	12. Was Decedent Ev	ver in U.S.	13. V	Vas Decedent of H	21798	Specify Yes or No- to Rican, etc.)		.S.A.	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Pscient Examirar mest be radified at	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	0	1	Yes, specify Cuba	an, Mexican, Puer Specify:	to Rican, etc.)		k, White, e	
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yla	2 should b and Ment is marked aumatic e	2	C. Oscar Singer						Annie M.			
a S	and 2 sh ealth and n 27 is n her traur		19a. Informant's Name/Relationship (Ty Herman L. Lookingb	· · · · · · · · · · · · · · · · · · ·	0.00	_	g Address <i>(Street</i> 2 Clyde '		ural Route Number	r, City or Town, S Sboro, M		
Baltimore,	es 1 ar of Hea f Item		20a. Method of Disposition				ition (Name of atory or other place			20c. Location - 0		
Ĕ	t. Pages tment of tant; If It		1X Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)			ope	Cemetery	11/4		Woodsbo		MD
Ba	permit. Pages 1 and 2 Department of Health of Important; If Item 27 is any Injury or other tra once.		21. Significantly of Funeral Service Licens	Xa De			Name and Address 04 S. Ma		rtzler Fu Woodsbor			
	-		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause on each line	he death. Do	not ente	r the mode of dyin	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
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68760	cate be	edical		l								
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o	f pregnancy					23d Date	of deliver	rv
o	the death cer y the attendin ched for use	Physician/M	in the past 12 months? 1 □ Yes 2 🔼 No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			Ectopic pregnancy Other (specify)	у		Mon		Day Year
S, T.	w requires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions cor	tributing to death but	not resulting	in the un	derlying cause give	en in Part I.	23e. Did tot	pacco use contri	bute to the	e cause of death?
Hecords,	require								1 🗆 Ye	s 2 No	3 ☐ Proba	abiy 4 ☐ Unknown
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VITal	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?	ospital:			2 DOA Othe		ath (Check only on	e)		
0	g Phy ter this teral di	n: To	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		Time of	3 DOA 28c. Injury Work	4/A Nursing F	łome 5 ☐ Reside)
SIO	tendin eath. or: Aft the fur	catio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day,	reary	Injury		Yes 2 □ No				
DIVISION	al or At s after d il Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	arm, stre	et, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier 1 ☐ Certifying Phys (Check only one)	sician. To the best of ter: On the basis of e and manner state	examination a	ge, death nd/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occi	e, and due to the curred at the time, d	ause(s) and mar ate and place, ar	nner as stand	ated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier	8			29c. License		2	9d. Date signed		Jay, Year)
	}		,					43091		11-3-		
			30. Name and address of person who co		ath (Item 23a)	(Type, P	TOLL	House	- Ave	Fre	eler,	ck, MI)
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 0 2008	32. Registrar	s Signatur	ade s						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 35667 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 23, 2008 **Physician** 2:00 A M Annette F. Levine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Prince George's Renaissance Gardens If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 9. C. (Month 9. ay, 1. eg.) | 1. | 5. Social Security Number 9. Birthplace (State or Foreign New Oorto 7. Age (In yrs. last birthday) **Funeral** 1 □ M XXF 121-09-3271 90 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Silver Spring Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3122 Gracefield Road CT-205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygience Important: If item 27 Is marked other that any Injury or other traumatic event, the angles. other traumatic event, the Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Perman Jacob Winer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3122 Gracefield Rd. CT-205 Silver Spring, MD 20904 Daniel Levine/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0|23|08 Chesapeake Crematory: 10/24/08 Beltsville, MD 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 years Physician Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant DOB: 10/19/1918 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? /es 2 X No Vital 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Levinë Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) IVING 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Division or this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of confider 29c. License number 29d. Date signed (Month, Day, Year) D24093 October 23, 2008 Jo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fair. Mark Parkhurst, M.D. 3110 Gracefield Rd. Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 4 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			1 - State Registrar AMEND#SperIN	JF. 11/5/08. FM	aryrari W.M - Co	Ce	ertificate of			Reg. No.	A A	35666
	Physicia	an	1. Decedent's Name (First, Middle, La	ist)	.,,				2. Date of De	eath Day	Year	3. Time of Death
	/Medic			Frank Lowen	stein				October	23	2008	5:45 a _M
	Examin	er	4a. Facility Name (If not institution, given					or Location of Deat	h	4c. County		
			Carriage Hill Be 5. Social Security Number 6.5		e (In vrs. I	ast birthda		Bethesda If Under 24 Hrs	. 8. Date of Bir	rth		gomery
	Funeral Director			1⊠M 2□F	94	Yrs.	Months Days	Hours Min.	Aprilary	10(* 1914		place (State or Foreign ntry) ennessee
	/land low at		10a. State 10b. County		10c. City	, Town or I	_ocation				1	0d. Inside City Limits
	a-f sh ified	tor	Maryland Montgo	omery				Kensington				1⊠Yes 2 No
	th the or 28; e not	Director	10e. Street and Number	<u>-</u>			10f. Zip Code			10g. Citizen of	What Cour	itry?
	ath wi	ral	4921 Aurora	_			_	20895			U.S.A	
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	de		 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 14. Rad Bla	ce - Americ ck, White,	
50	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates:	Navy WWI		1 ☐ Yes 2 ☒ No	Specify:		Specif		ucasian
2-00?p	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. . marked other than "natural", or Items 23a or 28a-f show .matic event, the Medical Examiner must be notified at		15. Decedent's E	ducation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	16a. Dec	edent's Usual Occu	pation	alsia a	16b. Kind of B		
7	thin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retir	e during most of wo ed)	rking	!		
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yland	the first Head of the ded of the sever	Be	17. Father's Name (First, Middle, Las	•					me (First, Middle	, waiden Surnar	ne)	
Š	should nd Me mark matic	욘	JUIIUS Land 19a. Informant's Name/Relationship	owenstein (Type. Print)		19b. Mai	lina Address (Stree	t and Number or R	tha Blach	per. City or Town	State. Zir.	Cade)
2	nd 2 salth ar 27 is r trau		Sallie C. Lowenstei	,				ive, Kensin		-		,
e,	item item othe		20a. Method of Disposition		20b. P	lace of Disi	position (Name of ematory or other pl	i	Date	20c. Location		wn, State
Ĕ	Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Gar	den of	Remembranc	ce	7/2008	Clarksbu	irg, Ma	iryland
pallimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euperal Service Lice	nsee		1	22. Name and Add Hines-Rinal	ress of Facility di Funeral ampshire Av	Home, Inc.	. Comina	Mora	zland 2090/
			23a. Part1. Enter the disease, or con	plications that caused	the death						,, rally	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			Heart	Failure				4	Onset and Death
-	/Medical		resulting in death)	Due to (or as			ratiule					
	Examiner	L	Sequentially list conditions,	U.		brillat	ion					
	led is it	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as								
,	execut and al-trar	Examiner	that initiated events resulting in death) Last	c. Corc			Disease	<u> </u>				
00/00	rificate be executed ng physician and as the burial-transit	ledical E		_ d								
	certificanding plans as the	Med	IF FEMALE:	00- 16								
סמ	w requires that the death cer been signed by the attendin should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal	death 3	☐Ectopic pregnan	су			ate of delive onth	ery Day Year
į.	The law requires that the death ate has been signed by the atter bage 2 should be detached for un	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
Į,	s that	by P	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the	underlying cause g	iven in Part I.	23e. Did 1	tobacco use con	tribute to th	he cause of death?
Spids	equire en siç ould b		Late Effects of Cer	ebral Vascula	r Acc	ident			1 🗆	Yes 2 No	3 ☐ Prob	ably 4 ☑Unknown
Š	law r	Completed	Chronic Obstructive	Pulmonary Di	sease				24a. Was		Were auto	ppsy findings available mpletion of cause of
_ ₹		Con							perfo 1∐ Yes	ormed?	death?	2□ No
N I I	certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			10	Ub a se	ath (Check only		2.5	
5	Phys r this ral di	- 1º	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpatie		ER/Outpation 28b. Time	EIK OLIDON	4 E Nursing i	Home 5 ☐ Resi	idence 6 Ott		у)
	nding th. r: Afte e fune	tion	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(<i>Month, Da</i> j n	y Year)	Injury	W W	ork?]Yes 2∐No				
ZIVIS	To the Hospital or Attending PhysIclan: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At ho c. (Specify	me, farm, s	street, factory, office		28f. Location (City or To	Street and Numi wn, State)	ber or Rura	al Route Number,
-	lospital hours uneral		29a. Certifier 1 ☑ Certifying P	nysician: To the best of miner: On the basis of	of my know	wledge, dea	ath occurred at the	time, date and plac	e, and due to the	cause(s) and m	anner as s	tated.
	the Ithin 24	Medical	29b. Signature and title of certifier	and manner sta				nse number				
	or wit	-	Zau. Signature and the of certifier				Zac. Licer			29d. Date signe	94 (C	
7	10		30. Name and address of person who	completed cause of d	eath (Itom	23a) (Tue	Print)	D35579		, 0 1	> 110	10
			Susan J. Miller, M		,	, , , , ,		05, Bethesd	a, Marylai	nd 20814		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra		ture						
	Registr	ar	OCT 27 20	US MAR	13		Sect 0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 10:17 am Robert Henry Lott October 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 X M 2 □ F Director 59 213-54-6390 November 12,1948 District of Columbia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show if than "natural", or items 23a or 28a-f ships Medical Examiner must be notified. Director 1 TYes 2 ₹ No Maryland Montgomery Colesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 717 Springloch Road 20904 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or iter Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🖾 No Specify. Specify: 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administration Actuary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Henry Lott ပ Eleanor Mae Case 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita T. Lott - Wife 717 Springloch Road, Colesville, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 11/07/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerosis of Coronary Vessels /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse gience of) attending physician and for use as the burial-transit death certificate be executed Diabetes Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Hyperlipidemia IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached ∃Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Morbid Obesity 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an After this certificate has autopsy performe 1 ☐Yes 2 K No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0066828 October 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

27

M. Aamir Ali, M.D., 10801 Lockwood Drive, #200, Silver Spring, Maryland 20901

320Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3567 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October Levine 23, 2008 8:30A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Potomac Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 28, 1914 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 → F Months Days Hours Min PA Country 213-44-5768 94 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Evanthor must be partified at MD Montgomery Potomac 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10600 Great Arbor Drive 20854 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be I Department of Health and Mental Important: If item 27 is marked o Harry Bratman Clara (Uknown) ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol N. Hankin - Daughter 10600 Great Arbor Drive Potomac MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1

Burial 2 □ Cremation 3
Removal from State King David Memorial 10/26/08 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atherosclerosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Osteoporosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed Failure to Thrive sician and burial-trans Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Por Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown ö the detached 9 Unknown signed by ٥. The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy certificate 1 □Yes 2 **□X**lo 2**X** No 1 Tyes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 📉 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31319 October 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

OCT

27

2008

DHMH 17 Rev 1/2001

Loreto S. Albiol MD 8218 Wisconsin Avenue Suite 305 Bethesda MD 20814

Règistrar's Signature

Registrar

KOR

31. Date filed (Mo

Year)

RAN

2008

MD

Registrar's Signature

MONTROSE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Carlton Guy Marvel 0700 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2/21/1943 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. DE 192-34-3557 65 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Experience must be notified at Director 1 ☐ Yes 文文 No MD Anne Arundel Odenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21113 1347 Chapelview Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 155 Yes 2 □ No 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1√EYes 2 ☐ If Yes, Give Year or Dates: 1961-1 ∐Yes 2√⊟No Specify. Specify: White Completed by 3 Widowed 4 Divorced 1981 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 5+ Loan Officer Mortgage 7 is marked other traumatic event, U Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley John Marvel Dorothy McDonnell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1347 Chapelview DR. Stella Marvel Wife Odenton, MD 21113 Department of Health Important: If item 27 any injury or other troone. 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 10/24/2008 Glen Burnie, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tran and Due to (or onsequence of) Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. signed I ignificant conditions contributing to death but not sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No After this certifical funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manne: Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Vatural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 of cert 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title

Registrar

31. Date filed (Month, Day, Year)

2008 OCT 2 2

Name and address of perso, who completed cause of death (Item

Registrar's Signature

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any higher or other traumatic event, the Medical Examiner must be notified at once.

Physicia /Medic Examin

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

•	For State Of Ma	aryland / L	•	rtment of F	lealth and N Death		gien Reg. N	7000	35673	
	1. Decedent's Name (First, Middle, Last)			2. Date of De Month		Day Year	3. Time of Death			
in al	Marilyn Joan 4a. Facility Name (If not institution, give street and number)		ack:		Location of Death	Octobe:	$\frac{19}{1}$	9, 2008 c. County of Dea	10:00 A ^M	
er	19 Bristol Drive				apolis	•		Anne Ar		
		e (In yrs. last bir	thdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9 Bi	rthplace (State or Foreign	
	284-30-3398 1□M XX 7 77	7	Yrs.	Months Days	Hours Min.	Jan. 16	ay, Yea	931 Ohi	Country)	
	Usual Residence of Decedent					1		702		
	10a. State 10b. County	10c. City, Town	or Lo	cation					10d. Inside City Limits	
혅	Maryland Anne Arundel Annapolis								1 □Yes 2√TNo	
ire	10e. Street and Number 10f.				Of. Zip Code 10g.			Citizen of What Country?		
a	19 Bristol Drive			21401			United States			
ner	11. Marital Status 12. Was Decedent	Ever in U.S.	13.	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No)-	14. Race - Am		
F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Wolf Yes 2 Wolf Yes 2 Y			1 ☐ Yes ② No Specify:				7.71		
by	3 X Widowed 4 □ Divorced Year or Dates:		ALANO Specify.					Specify: W	viiite	
Completed by Funeral Director	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Bus (Specify only highest grade completed) (Give kind of work done during most of working							Kind of Business	s/Industry	
ldu	Elementary/Secondary (0-12) College (1-4or 5+)									
S	5+]	Librarian					vernment	
Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)						en Surname)			
၉	Frank Lando Elizabeth Ault									
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								•	
	Jill D. Meng / Niece							Ohio 44		
	20a. Method of Disposition	20b. Place of cemete.	f Dispo ry, cren	sition (Name of natory or other plac	e)	Date	20c.	Location - City o	r Town, State	
	1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Balti	more	e Cremato	ry 10/2	1/2008	Ba	ltimore.	Marvland	
	4 Donation 5 Other (Specify) Baltimore Crematory 10/21/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc.									
	147 Duke of Gloucester St. Annapolis, MD 21401									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between									
	Immediate Cause (Final Onset and Death									
er	disease or condition resulting in death) a. Due to (enas a consequence of):									
	Cardy recovered avoid									
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the consequen									
Examiner	cause. Enter Underlyin Cause (Disease or injury that initiated events C.									
Exa	resulting in death) Last Due to (or as a consequence of):									
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Completed by Physician/Medical										
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ıysi	1 Tyes 2 ANO 9 Unknown 9 Unknown									
H /	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								to the cause of death?	
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ם						auto		prior to	completion of cause of	
ပိ						1 □ Yes	2	No 1□Y∈	es 2 No	
Be	25. Was case referred to medical examiner? Hospital: Description of Death (Check only one)									
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jo	1 Natural 5 ☐ Pending (Month, Da	ay, Year)	injury	Wor		Zod. Describe	TIOW IN	july occurred		
ical	2 Accident investigation M 1 Yes 2 No 3 Suicide Suicid								Rural Poute Number	
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ပ္	On Cartifier 1 - 1 - Cartifying Dhysician: To the hest of my knowledge death accurred at the time date and place and due to the saured a and manner as stated									
Medical Certification: To	29a. Certifier 1 Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Mec	29b. Signature and title of certifier	7		29c. Licens	e number		29d. l	Date signed (Moi	nth, Day, Year)	
10-70-700									800	
\	Jummy (Show (MI) 120037									
)	30. Name and address of person who completed cause of	death (Item 28a)	(Type,	Print)	1/ (/0,1	of Chro	1	(+ m	v 2014	
	31. Date filed (Month, Day, Year) 32. Jegist	rar's Signature	+	0564 1	11- Coul	1) 5/1/	0,	Ju 18 X	10, 01001	
te ar	OCT 2 2 2008	es a M	A	Carrie .						
211	99: 47 2040	-2 /5	1	ASSEL!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35674 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Roy Mercer Nelson 0ctober 2008 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 808-F Stratford Way Frederick Frederick 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**⊠** M 2□ F Michigan Director 366-32-7325 1931 July 7. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Evantings must be notified at 1 Wes 2 □ No Director MD Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 808-F Stratford Way 21701 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Eventine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify.White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Account Executive Advertising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Maurice Nelson Florence Gertrude Mercer ပ 19a. Informant's Name/Relationship (Type. Print)
Gretchen W. Nelson/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808-F Stratford Way Frederick, MD 21701 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 10/24/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Frome Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** la1 ignant 1 Paks /Medical Due to (or as a mass uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has autopsy performed? certificate Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 14. Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the within 2 and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) October 23, 2008

600

State Registrar 31. Date filed (Month, Day, Year)

OCT 2 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type_Print)



Drive Fradenck, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Geniveve Jeannette Pearson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WIRDMICO Peninsula RegioNAL If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number 1 ☐ M 2 💆 F Days Hours Min. 78 217-26-2810 4/4/1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Salisbury 1 X Yes 2 □ No Director Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 8231 Arden Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2X No If Yes, Give Year or Dates Specify white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Eckes John Wielgosz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8231 Arden Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Clarence O. Pearson/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore of Maryland 20c. Location - City or Town, State Date 1k Burial 2 ☐ Cremation 3 ☐ Removal from State $10/27/\phi 8$ Hurlock, MD 4 □ Donation 5 □ Other (Specify) Veterans Cemetery 22. Name and Ad less of Facility and Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Furreral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unkn. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 □Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1-Inpatient 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

within 72 hours after death with

permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene important: If item 27 is marked other than "ne any injury or other traumatic months."

Baltimore, Maryland 21215-0036

burial-trar physician at the burial attending p for use as t the ģ s been signed b should be deta has e 2 s page

requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

Physician;

Hospital or Attending

after death. Director; of in by the f

Examiner Physician/Medical ð Completed After this certificate function function function for the function of the func Be Certification: To

No unc... within 24 hours and To the Funeral Dir

Medical

29b. Signature and title of certifier 30. Name and address of person

31. Date filed (Month, Day, Year) State OCT 24

1-Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28a. Date of Injury (Month, Day, Year)

5 Pending investigation 6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 □ Yes 2 □ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainted to state.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HUU56197

Salista

22/08

ho completed cause of death (Item 23a) (Type, Print) 100E.

Frar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** NOVEMBER 02 2008 9:23 ELIZABETH REMSBURG VTOTA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🔀 F 88 Maryland July 27, 1920 214-42-1241 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedler Examination relified at 1 ☐ Yes 2 X No Director Maryland Frederick Middletown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21769 7327 Old Middletown Rd. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ∐Yes 2X No If Yes, Give Year or Dates: Specify: ģ 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Item M. assembly line eyeglass factory 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey A. Long Sarah Keeney ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger A. Remsburg/son 9613 Harmony Rd. Myersville, MD 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Chapel Cemetery 11/5/2008 nr. Libertytown, MD 4 Donation 5 Dother (Specify) 21. Signature / Funeral Service Livers (22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Cardua disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Wronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner and Due to (or as a consequence of) the attending physician Physician/Medical the as nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month ō Day Year 5 Other (specify) □Yes 2 10 No 9 Unknown 9 Hlnknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 10 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s nas autopsy performed certificate 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2-No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one)

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, Physician: Pospital or Attending P 24 hours after death. Funeral Director: After t 24 hours a completely To the I

Baltimore, Maryland 21215-0036

State Registrar

Medi

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Mudusar Raza



MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

MDD66166

Frederick, MD 21701

29d. Date signed (Month, Day, Year)

08

DHMH 17 Rev 1/2001 ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 harles /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1X M 2□F April 4,1929West Virginia 79 236-38-6084 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show Examiner must be notified at 1 ☐ Yes 2√∑ No Director Cabell West Virginia Huntington 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò 25705 U.S.A. 23a 592 Fairwood Road Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? or items 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or ite 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White <u>}</u> 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) C&O Railroad Computer Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Margaret Binns Robert A. Rappold ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25705 19a, Informant's Name/Relationship (Type. Print) 592 Fairwood Road, Huntington, West Virginia Health tem 27 i A.Frances Rappold Department of Healt Important: If item 2: any injury or other tonce. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 Cremation MontgomeryMem.Park11-10-08|London,West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service License 6009 Harford Road, Baltimore, Maryland21214 muhau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 week disease or condition resulting in death) Denil Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami physician and as the burial-tran Due to (or as a consequence of) resulting in death) Last

Physician /Medical Examiner

death with the

3altimore, Maryland 21215-0036

as for use ate has been signed by the a page 2 should be detached funeral director,

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician/Medical 2 Completed Be ၉ Certification:

23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Day Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 X No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 2 No 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation M 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ne and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

24 hours after death. Funeral Director: After this

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Hospital

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Registrar

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State

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32. Registrar's Signature

ton Court, Cumberland, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 U U 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 19, 2008 10:50 A^M Bruce N. Rogers, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 2/23/1958 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ₩ 2 □ F Min. Months Days Hours Texas 219-78-7222 50 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experience must be notified at 1 ☐ Yes 2 TXNo Director Anne Arundel Crofton Maryland 10a. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 1505 Lowell Court 21114 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black. White, etc Armed Forces? 1 MiYes 2 □ No If Yes, Give Year or Dates:1979-89 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) <u>Warehouse</u> years Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental pe h and Mental Phyllis Ann Harding Bruce N. Rogers ည Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 2900 Shipmaster Way, #222, Annapolis, MD 21401 Justin N. Rogers/ Son 20a. Method of Disposition
1 ☐ Burial 2 Discremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10-21-08 | Edgewater, MD Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thrus thing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4 ☐ Pregnant at time of death 5 Other (specify) 1∐Yes 2∐No cate has been signed by the page 2 should be detached 9 ☐ Unknown o. 9 Unknown ۵, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 💢 0 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this of the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Division 1 Natural Accident 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address f person who completed cause of death (Item 23a) (Type, Print) Amy R. Crowder, 2001 <u>Medical Pkwy., Annapolis, MD 21401</u> 32 Registrar's Signatu 31. Date filed (Month, Day, Year) OCT 2 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month 0/20/2008 2:15pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbor Health & Rehab Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 1/25/1905 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 🛣 Days Hours $\overset{\scriptscriptstyle Country)}{\mathsf{Scotland}}$ 103 Director 116-26-9238 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 ☐ Yes ⊋⊋ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 130 Hearne Rd. #1306 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ENo Specify þ Specify: White 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Christopher Smith Jane Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Glessner 130 Hearne Rd. #1304 Friend Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State Atlantic Crematory 10/22/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner i or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performs 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 흔 1 🗌 Yes 2P No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D hours 29a. Certifier Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) OCT 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** November 1, 2008 01:00 A^M Ralph Morris Sprout /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 32 Eastview 8. Date of Birth (Month, Day, Year) Ceci1 Drive E1kton If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 79 220-22-1941 Director 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 Town 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 32 Eastview Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 212/15-0036 Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Morris Sprout Marion Stocktill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Regina G. Sprout/Wife 32 Eastview Drive, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 4, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cherry Hill Methodist Cem. 4 Donation 5 Dother (Specify) Cherry Hill, MD 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed? Yes 2 No page or Vital 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Division Hospital or Attending injury 5 Pending within 24 hours after control to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) 3 me and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Wayne Morris Souder 11/1/2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 928 Parsons Dr. Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F 218-34-6465 70 Director 6/6/1938 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County show in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Maryland Dorchester Madison 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 928 Parsons Dr. 21648 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1956 - 1962 Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amos Edward Souder, II Mildred Leona Poe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Charlotte Souder / Wife 928 Parsons Dr., Madison, MD 21648 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/3/2008 4 ☐ Donation 5 ☐ Other (Specify) Mid Shore Cremation Center Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home P.A., 308 High St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Squentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

Division or Vital Records, P.O. Box 68760 has

To the Hospital or within 24 hours aft To the Funeral Di

completely

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 2 ☐ Feta 4☐ Pregnant at time of c 9☐ Unknown				Month Day Year					
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.	1	use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
Congestive	/teart	7ailure		24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 → 100					
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	Home Residence	Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred					
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injury - At he building, etc. (Special	ome, farm, street, factify)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)					
	nysician: To the best of my kno miner: On the basis of examina and manner stated.				s) and manner as stated. nd place, and due to the cause(s)					

29c. License number

3. Time of Death

Dorchester

USA

Oil Industry

29d. Date signed (Month, Day, Year)

Ave, Suite 1 Cambridge MP21613

Birthplace (State or Foreign Country)

Maryland

White

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

1:05 P M

State Registrar

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Certification: To

Medical

29b. Signature and title of certifier

19900 31. Date filed (Month, Day, Year)

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30. Name an inddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35683 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 28, 2008 Physician Month 8:30PM M Smith Marie Carmen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Golden Living Center Cumberland Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Min. Months Days Hours Director Sep 21, 1923 235-32-6219 Mexico Usual Residence of Decede d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. The marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director MD Allegany Cumberland 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty St. Apt. 508 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ YXKs 2 ☐ No Specify. Specify: ð 3 ☐ Widowed 4 ☐ Divorced Mexican white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Victor Manuel Chapela Maria Lusia Diaz Ceballos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Reindl daughter 410 East US 50 O'Fallon IL 62269 Department of Health Important: If Item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ⊓ent of ⊩ 1 ☐ BXial 2 ☐ Cremation 3 ☐ Removal from State 10/31/2008 Queens Point Cemetery Keyser WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List vily only cause on yach line.

Immediat Cause (Final disease (Final disease) condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. physician Completed by Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9∐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

29b. Signature and title of certifier

30. Name and address of per

31. Date filed (Month, Day, NOV 1 0

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3

316

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nations

29c. License number

29d. Date signed (Month, Day, Year)

8

amended item 10B/10-27-08/wchd/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 6:32 AM RICHARD SEYMOUR 10 -22 - 2003 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Constal Hospice at the Lake Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Days Vear) Months Hours 1 XM 2 ☐ F 21. 1936 PENNSÝLVANIA FEB. 169-28-5806 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Worcester 1 ☐ Yes 2 █No MARYLAND -WICOMICO BERLIN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 CAPE CIRCLE 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1954-57 1 ☐Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FIRE DEPT. DISTRICT CHIEF 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELIJAH SEYMOUR BLODWYN JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH A. SEYMOUR/WIFE 7 CAPE CIRCLE, BERLIN, MARYLAND 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify)ENTOMBMENT 4 Donation FAIRVIEW MEMORIAL PK: 10/29/08 MOSCOW, PENNSYLVANIA 21. Signature of une al Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I inter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final a. END STAGE CHRONIC OBSTRUCTIUR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Wedical Explainer is ust be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

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Separtment of

Maryland

Baltimore,

physician and s the burial-transit attending p for use as t signed by the a been si After this certificate has funeral director, page 2 s

Examiner Physician/Medical þ Completed Be ၉ Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records. P.O. Box 68760

IF FEMALE 23b. Was decedent pregnant

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

Natural Natural

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

2 No 3 Probably 4 Unknown

1 □Yes 2 □No 26. Place of Death (Check only one)

1 ☐Yes Z☐No

Other: 4 Nursing Home 5 Residence State (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number DO058410 29d. Date signed (Month, Day, Year) 10-22-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARKS Gituttun COAS

31. Date filed (Month, Day, Year) OCT 2.4

5 Pending

investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

0 Box 1733 SACY BUY UP 21802

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within 24 hours a

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completely filled

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VA

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 35685 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOV.2,2008 7:50P RONNIE LEE TURNER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10658 WATER HICKORY CHARLES COURT WALDORF If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Days 1 M 2□F Months Min. 341-30-0289 70 Director APR.15,1938 CASEY, ILL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 X No MD. CHARLES WALDORF Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 10658 WATER HICKORY COURT 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 NYes 2 No NAVY If Yes, Give 1.957-77 Year or Date 1.957-77 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry A 27 is marked other than "a traumatic event" the M Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST MATE E-7 U.S.NAVY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ OLIVER TURNER FLO COOPER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: if item 27 is any injury or other trau once. 10658 WATER HICKORY CT. BETTY JO TURNER-SPOUSE WALDORF, MD. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETS.CEM 11-7-08 CHELTENHAM, MD. 2. Name and Address of Facility 21. Signature of Juneral Service Licensee **№**100479 RAYMOND FUNERAL SERVICE, P.A. liar LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f I□Yes 2□No 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗌 No []Unknown 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has e 2 s certificate has frector, page 2 autopsy performe To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 10 Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ē 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 2 Accident (Month, Day Year) 5 Pending М 1 ☐ Yes 2 ☐ No s after death.

ii Director: A

od in by the fu death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and
To the Funeral Dir the Hospital 🛏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature, NOV 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month WEEKES **Physician** 838 Oð /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 88 155-03-1032 Director July 31 1920 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanture of the rolling at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2XXNo 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21403 U.S.A. 7015 Bay Front Drive within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2XXXNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗷 No Specify ģ White 3XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Stenographer Court System 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. White Etta Maria O'Reilly ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Apparolis. Maryland 21403 19a. Informant's Name/Relationship *(Type. Print)*Tara Stout/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of I Important: If ite any injury or ot XXBurial 2 Cremation 3 Removal from State 10/25/2008 Holy Cross Cemetery Yeadon, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalus Toneral Pervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician our /Medical Due to (or as a con sequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 □ Yes 2 No of Vital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 ANo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14⊈Natural 2 ☐ Accident Division 5 ☐ Pending investigation nours after death.

neral Director; A
filled in by the fu r death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and mannerstated. To the I within 2 29b. Signature and title of certifie W

State

State Registrar

31. Date filed (Month, Day,)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death ARCIA 153UM 2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 □ M 2 95 214-42-4072 March 28, 1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Arnold Anne Arundel 1 ☐ Yes 2 XNo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 510 Bay Hills Drive 21012 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐Yes 24TXNo 1 ☐ Yes 2 X No Specify. White **3℃**Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appliance Store Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ernest M. Parker Emma Sheppard 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Parker/brother 510 Bay Hills Drive Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore Crematory 10/24/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of uneral/Service Licensee 00 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? unstruct 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

hysician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural",

is marked other than "natural aumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Heath and Mental Hy. Important: If Item 27 is marked othe any injury or other traumatic auchant.

within 72 hours after

Baltimore, Maryland 21215-0036

Director

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burial-trai ed by the attending physician detached for use as the buria cate has been signed by a page 2 should be detach certificate funeral director, After this

Physician/Medical

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31. Date filed (Month, Day, Year)

the death certificate be executed

Box 68760.

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Division or Vital Records,

Certification: al or Attendi after death. I Director: A d in by the fu filled in by To the Hospital o within 24 hours aft To the Funeral Di Medical State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 **1** No 2□No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Vear 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and finner stated. 29a. Certifier (Check only 29b. Signature and title of rtific 29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

ho completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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2008

Physician /Medical Examiner the death certificate be executed

the Maryland

Baltimore, Maryland 21215-0036

Box 68760.

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Records.

signed by the attending physician and d be detached for use as the burial-transit has this certificate

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The law requires that s after death.

I Director: After this of in by the funeral d

of Vital the Hospital or Attending Physician: 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 10/30/08 Unknown Accident investigation 1 ☐Yes 2 ☐No 28f. Lastion (Street and Number or Rural oute Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 11 Geranium Place thin 24 hours aft the Funeral Di mpletely filled in home Middle River Mo Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 29b. Signature and title of certifier 29c. License number wp1 29d. Date signed (Month, Day, Year) 08 MD 30184 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOSKIM & SHIBM 33. G/ JOSSOH BALLWARE GREENE ST. 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

08-08331	
Andre Adams	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dre Adams		St 1- For State Registrar	ate of Maryla	-	rtment of tificate of		and	Menta	al Hygid		2 0 g. No.	08	3568	
Physicia edical Exami	an/	1. Decedent's Name (First, Middle Andre Adams	e,Last)							Date of Deat	h		Time of Death	
	iei	4a. Facility Name (if not institution	n, give street and nu	mber)	4	b. City, Tov	vn, or Lo	cation of I		Month Day Year November 6, 2008			10241113	
		1412 Hadwick Drive #	D	,		Essex					Baltimore County			
Funeral		5. Social Security Number 2 1 5 - 8 2 - 0 1 4 3	ast birthday)	If Under Months	1 Year Days	If Under 2	24Hrs. 8. Min.	Date of Birt	th(MM/DD/YYYY)	 Birthpla Foreign 	ace (State or			
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on						100	d. Inside City Limits	
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r death with the Maryland or items 23a or 28a-f shor must be notified at once.		1412 Hadwic		#D	6 13 Was		122		2 / Specifi	y Yes or No-	USA o- 14. Race - American Indian, Black,			
eath w	Funeral	1 Never Married 2 X M				es, specify					White, etc.			
after d	by Fi		orced If Yes, Give Yea	ır	1	Yes 2 🛚	No .	specify:			Specify:	Blac	ck	
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5-06 led wii Hygier other the M		17. Father's Name (First, Middle	•	· · · · · · · · · · · · · · · · · · ·	1		- 1				Maiden Surname)			
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b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once	2	Ernestine M	eans/ Mo	ther							more,			
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Baltimo permit Page Department o Important: injury or ott		21. Signature of Funeral Service	Licensee										eral Home	
Physician	11	23a. Part I. Enter the disease, or	complications that c	aused the death	. Do not enter th	10 B ne mode of	e⊥a dying, su	<u>ir</u> R uch as car	Coad diac or res	Balt spiratory arr	imore, est, shock, or hear	rt A	21206 Approximate Interval	
Medical kaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a Hypert	ensive		clero	tic	card	iovas	scular	disease		Between Onset and Death	
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Box 6876(e death certificate the attending physed for use as the b	Physician/M	23b. Was decedent pregnant in t past 12 months?	I Live I	oirth nant at time of de		tal death	3	Ectopic	pregnancy		Month	Day	Year	
Box le death the atte	nysi	1 Yes 2 No 9 Un	known g Unkn		5 Ott	ner (Specif	y)							
P.O. es that th igned by be detach	by	Part II. Other significant condi	tions contributing t	o death but not i	esulting in the u	nderlying o	ause giv	ren in Part	t I.	23e. Did to	obacco use contrib		cause of death? y 4 V Unknown	
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Divis Hospital or A 24 hours after Funeral Dire	Certification:	4 Homicide dete	ermined (Specify)							or Town, S	State)			
Division of Vital To the Hospital or Attending Physician: within 24 hours and re dath. After this certif or the Funeral Director: After this certif completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be aminer: On the basis	st of my knowled of examination a	lge, death occur and/or investigat	red at the ti ion, in my d	me, date	e and plac death occu	ce, and due urred at the	e to the caus e time, date	se(s) and manner and place, and du	as stated. ue to the c	ause(s)	
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		Thenday W	1 X	There	nos		O.C.M	I.E.	00	CME	November	7, 2008		
		30. Name and address of person	•			111 De-	n C+	of Par	timoro 1	MD 2420	1			
	tate	Theodore M. King, Jr 31. Date filed (Month, Day Year)		ant Medical estrar's Signat				et, bait	umore, ľ	MD 2120	1			
Regis		NOV 1	2 2008	ed strar's Signat	St A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 200⁸ **Physician** November 4:00 P.M Allen Kay Joan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 2, Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Months 1 □ M 2 👿 F Mississippi 42 Yrs 1966 578-94-9167 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be mailfied at 1 X Yes 2 □ No Director Maryland | Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20720 U. S. A. 12706 Prospect Knolls Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐Yes 2XNo Specify Specify: <u></u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Computer Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Administrator Technical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Marjorie Eleanor Thomas Vincent Keith Minnick ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12706 Prospect Knolls Drive, Bowie, Maryland 20720 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. Barry Allen / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/12/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home det frem 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Breast Cancer Physician 12 Yrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an s certificate has t irector, page 2 sl autopsy perform 1 □Yes 2 No Division of Vital Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1∐Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in 2 Acciden 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. To the l within 2 To the l 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 11, 2008 D0062607 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

Alida Espinoza, MD., 7525 Greenway Center Drive, Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, 2. Date of Death Nov. , 200 8° **Physician** /Medical 4b. City, Town, or Location of Death Examiner Baltimore ttome owson ence Age 96 5. Social Security Number 217-03-9115 Birthplace (State or Foreign Country) yrs. last birthday) **Funeral** Days Months **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandance, ust be not that as Baltimore 1 XYes 2 □ No Funeral Director M.D10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ecedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married American Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Š 3 ₩ Widowed 4 □ Divorced Year or Dates: Indian Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DO NOT use retired)

SYEWEY 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ndary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) Rural Route Number, City MD 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13.08 21. Signature of Fuheral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Crisace or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant in the pest 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Obstructure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2♣No 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signatur@and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Charles ST.

Suite 209 Touson MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Black

12

31. Date filed (Month, Day, Year)

North

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 🙋 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year :12 109 den 0 ta 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore City Decol If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 5. Social Security Number 1 M 2 F Year) Months Days Hours 11/30/1945 62 Maryland 218-44-1313 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Nes 2 No **Baltimore** MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 701 Arlington Ave. Apt. 501 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2X No Specify: Black Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Barmaid Bars 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Brogden Margaret Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2636 W. Lafayette Ave. Balto., MD 21216 Denise L. Brogden 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Lansdowne, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenties 638 N. Gilmor St.Balto., MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 0651 Fulmonary Disease home Due to (or as a consequence of): DOXIE Due to kr s a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 HNO 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 1√0

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Box 68760, attending p Division of Vital Records, P.O. has been signed by the e 2 should be detached certificate ha After this (Il Director: ,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Eveminer must be notified at

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Ith and Mental Hygiene.

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

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Medical Certification: To

29b. Signature

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one

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within 24 hours a

To the Funeral C

completely filled i

State Registrar

Martina 31. Date filed (Month, Day, Year)

and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

29d. Date signed (Month, Day, Year)

November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 7:50 A Brown November 04. /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 ☐ F 90 Director 217-34-0795 /14/1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD Prince Georges Director Hyattsville 1√E Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or ; 6806 Highview Terrace #103 20782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 ₩ Widowed 4 Divorced th and Mental Hygiene.
7 Is marked other than "natun traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be Short Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health and Theresa Volel/ Daughter 4116 East West Highway, Hyattsville, MD Pages 1 and 20782 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If it any Injury or or Mt. Olivet Cemetery 11/08/2008 Washington, DC 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 23a. Part1. Enter the disease, or complication; that aused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DIDPULMOR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physiciar Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy certificate 1∐ Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 N Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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732579

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

GREGIBELT MARY

NOVEMBER 5 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23e, 24a, b, 25perPHYS, ,G885, 11/12/08, WS #31

State of Maryland / Department of Health and Mental Hygiene for State Registrar 35694 Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Пау Month Year **Physician** 0127 NHTI October)/// 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tospita timore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 216-30-6284 1 M 2 F Hours 76 MARYLAND Director 8 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wodfoal Expirent: ust the notified at once. NIA 1 Yes 2 No Director BALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? 2309 BRYANT U.S.H. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: BIACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL ERIATRIC NIURSES ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BROOK NATHANIEL JESSIE SUSIE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) 9529 DAK TRACE WAY, RANDALLSTOWN, MD 21133 EDITH ROBIN FROIX Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State LAUREL, MARYLAND CEM: 11-06-2008 4 □ Donation 5 □ Other (Specify) North Fulton Avenue MD 21217 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARDIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit law requires that the death certificate be executed Stable Lung Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ficate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 🕱 No 24b. Were autopsy findings available prior to completion of cause of death? certificate | 2 XNo Division of Vital 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Hospital or Attending Injury 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Name and address of person who completed cause of death (tem 23a) (Type, Print) 150 Date filed (Month, Day, 32. Registrar's Signature Year! State Registrar

DHMH 17 Rev 1/2001

Amend #26,perMD g885 11/12/08 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

35695

			For State Registrar		State of Ma	-	eparime Certifica			•	gien Reg. N			
	Physici	an	1. Decedent's Name (First, Dorothy	Middle, Las	Rutl	h	Pomm	- t- t-		2. Date of De Month	D	ay Yee	r	e of Death
-	/Media	al	4a. Fecility Name (If not ins	titution aire			Benne		Location of Death			c. County of De		46 P M
	Examir	er	710 Hamlen R	_	Street and number		1	Bur				Anne Ar		
3	Funeral Director		5. Social Security Number 212–26–7478		ex 7. Age	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. J					rth sy, Yea 5, 1	929	Birthplece (Sta Country)	ate or Foreign
	land wo		Usuel Residence of Deced	County		10c. City, Town o	or Location						10d. Insid	e City Limits
	e Man	ctor	MD Ana	ne Aru	ındel	Glen H	Burnie					1 ☐ Yes 2 ☐ No		
	with th	Funeral Director	10e. Street and Number	D 1				p Code			_	itizen of What	Country?	
	ns 23	erai	710 Hamlan 1	KOAQ	12. Was Decedent B	Ever in U.S.	210		spanic Origin? (Si	pecify Yes or No		14. Rece - A	merican India	٦,
036	hours after death with the Maryland turst; or ttems 23a or 28a-f show at Exeminant be notified at	by	1 □ Never Married 2 □ Dir		Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	If Yes, sp		spanic Origin? (S) n, Mexican, Puerto Specify:	o Rican, etc.)		Black, W	hite, etc. White	2
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "natural", or Hems 23s or 28s-f show other then "natural", or Hems 23s or 28s-f show event, the Medical Examirer must be notified at	Completed	(Specify only Elementary/Secondary (lucation de completed) College (1-4or 5	+)	fe. DO NOT	ork done d use retired,	luring most of work	king		Kind of Busines	ss/Industry	
	filed v Hygie other t	e Co	17. Father's Name (First, N	fiddle, Last)		Sea	mstres	SS	18. Mother's Nam	ne (First, Middle		rail n Sumame)		-
/land	Mental rked o	To Be	Allen P. Var						Margare			,		
Mary	2 should and Men ie marke surmatic		19a. Informant's Name/Re		0		-		and Number or Ru		-		, Zip Code)	
	s 1 and f Health item 27 other tr		Mrs. Cather:		Montague,				ad Glen 1	Burnie, Date		21061 Location - City	or Town State	
Baltimore,	Page lent o nt: If		1 Ø Burial 2 ☐ Crem • 4 ☐ Donation 5 ☐ Of	ation 3 🗆 her (Specify		20b. Place of D cemetery, Meadown	idge M	lem. I	Park 20	7. 14, 008	E1k	ridge,	MD	
g	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral S	ervice Licen		61121			s of Facility S11 2nd Aver					
	Physician /Medical Examiner		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ase, or comp a. List only	a. Vy/V		enter the mo		g, such as cardiac	or respiratory a	rrest,		9nset a	mate Between nd Death norths
Self.	uted i insit	Examiner	Sequentially list conditions if any, leading to immediate cause (Disease or injury	•	b. Due to (or as a	consequence of)								
8/60,	lificate be executed g physician and as the burial-transit	edical Exa	that initiated events ' ' resulting in death) Last		Due to (or as a	a consequence of)								
٥	ntificat ng phy e as th		IF FEMALE:	- 1										
Ö. 00	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown		23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s					23d. Date of o Month	lelivery Day	Year
cords, P.	requires that the een signed by th hould be detache	by	Part II. Other significant co	onditions co	ontributing to death bu	it not resulting in th	ne underlying	cause give	n in Part I.	23e. Did t		use contribute		of death?
Ľ	ysician: The law re is certificate has bee director, page 2 sho	Completed								24a. Was auto perfo 1 \(\text{Yes}		prior t death	autopsy findir o completion ?	ngs available of cause of
ק ק	ician: sertific ector,	Be	25. Was case referred to mexaminer?		Ha anitali			0.1	26. Place of Dea		-			
0 0	£ 5 %	lon: To		Pending nvestigation	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	y 28b. Tim	e of ry M	28c. Injury Work	4 Nursing H	ome 5 A Resi 28d. Describe			pecify)	
DIVISION	To the Hospitel or Attending Physician: whith 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 0	Could not be determined		ry - At home, farm . (Specify)				28f. Location (. City or To			Rural Route f	lumber,
	ne Hospite 24 hours 16 Funera	Medical C	29a. Certifier (Check only one)	rtifying Ph	ysician: To the best of liner: On the basis of and manner sta	examination and/o	eath occurred r investigation	at the time	e, date and place, inion, death occur	and due to the red at the time,	cause(date ar	s) and manner nd place, and d	as stated. ue to the caus	60(s)
ľ	To th comp	Ĭ.	29b. Signature and title of o	certifier			29	c. License	number		29d. D	ate signed (Mo	nth, Day, Yea	r)
,	7		Allis	-11	Villin 1	ug		000	1041		11	1101	08	
	6		30. Name and address of p	erson who	completed cause of de	path (Item 23a) (Ty		erfie	ld Road	Suite A	G14	n Ruzz	ie Mn	21061
8	Sta Registr	100	31. Date filed (Month, Pay NOV 1	2008	32. Registra	U	alles .		- ALV CACE	Durite H	010	on Bull	re, m	21001

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 9. **Physician** EDWIN R. BROOKMAN /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/12/1948 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M M 2 □ F 461-84-0649 60 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 28a-f show traumatic event, the Medical Exactions must be notified at Director MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? or items 23a or 14805 FALLS RD 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 YRS Elementary/Secondary (0-12) D.A.V ADMINISTRATOR ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWIN H. BROOKMAN PATRICIA J. CARREER P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i. Pages 1 and 2. The and 2. The and 27 is SUSAN T. BROOKMAM(WIFE) 14805 FALLS RD COCKEYSVILLE, MD. Item 27 other to 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MOUNT CREPTALE 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16024 YORK RD MONKTON, MD. 21111
Approximate Interval Between Onset and Death GREEN MOUNT CREMATORY 11/12/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee Rus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ADULT RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): OBSTRUCTIVE SLEEP APNEA and Due to (or as a consequence of): ding physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

Reg. No.

USA

Specify:

3. Time of Death

Year 2008 4:07FM

Birthplace (State or Foreign
Country)

10d. Inside City Limits

1 ☐Yes 2 No

Baltimore

CONNÉCTICUT

14 Race - American Indian

WHITE

21030.

autopsy performed? Yes 2 No 1 □Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

Day

Year

26. Place of Death (Check only one,

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐Yes 2 ☐No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year! D24034

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

ner stated.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

MORBID OBESITY

5 Pending investigation

6 Could not be determined

Hospital:

25. Was case referred to medical examiner?

27. Manner of Death 1 Natural

2 Accident 3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of cert

31. Date filed (Month, Day, Year)

TIMOTHY LOW.

29a, Certifier

7601 OSLER DRIVE. TOWSON. MARYLAND Registrar's Signature

28c. Injury at Work?

State Registrar

DHMH 17 Rev 1/2001

P.0. Division of Vital Records,

the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the spage 2 should be detached to certificate

ģ

Completed

Be

Certification: To

Medical

After death. neral Director: / within 24 hours a

To the Funeral C

with the Maryland 28a-f show if than "natural", or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 127 is marked other than "r. r traumatic event permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. 27

21215-0036

Saltimore, Maryland

Physician /Medical Examiner

burial-tran physician at the burial Box 68760, been signed by the a Ö ۵. Division of Vital Records, certificate has brieged in rector, page 2 s

the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, p within 24 hours a

To the Funeral D

completely filled i

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7, 2008 2008 6:45 AM November Alvin C. Blankenship 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 23 Year) 1927 9. Birthplace (State or Foreign 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Months Virginia 1 X M 2 □ F 231-24-0924 81 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Potomac 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 United States 12024 Edgepark Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Engineering President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otho William Blankenship, Sr. Laura Ruth Bohon ဥ 19a. Informant's Name/Relationship (Type. Print) Jeanette L. Blankenship/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12024 Edgepark Court, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State November Gate of Heaven Silver Spring 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01544 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2X No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AWAD ARSHAD M.D DOO 67782 November 07, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Jawad Arshad MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 3 2008 18:05 [™] D. Eileen Beach November 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 1 ☐ M 2 🛣 F 577-56-7139 98 February 26, 1910 Washington, D.C. Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 1 Tyes 21X No. Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18003 Mateny Road 20874 #111 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Labor Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dugan Isaac Rose Teer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gerald T. Beach/ Son 18810 Liberty Mill Road, Germantown, Maryland 20874 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition of the place) Montgomery Crematorium, November 2008 November 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M01532 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Lieuce or injur) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 23d, Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an

Physician /Medical Examiner

Physician

Examiner

10a State

Funeral

Director

28a-f show

Directo

Funeral

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Completed

Be

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d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

7 is marked other traumatic event, 11

permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.

the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Anous after death.

Eunoral Director: After this certificate has been signed by the attending physician and selly filled in by the funeral director, page 2 should be detached for use as the buriar-transit

Division of Vital Records, P.O. Box 68760,

080

Eileen

Beach, To the Hospital c within 24 hours af To the Funeral D completely filled i State

Physician/Medical ğ Completed Be Certification: To

Medical

29a. Certifier (Check only one)

25. Was case referred to medical examiner? 1∐Yes 2⊠No 27. Manner of Death 1 Natural 5 Pending investigation 2 Acciden

6 Could not be determined 3 Suicide 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Inpatient

28a. Date of Injury (Month, Day, Year)

29c, License number 29d. Date signe Mayland D6 7986 (1/3/08

1 □Yes 2 □No

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy perform 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Dr. Yuneng Li, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) NOV 1 2 Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 **Physician** 10:10 PM 2008 November Norma Brach /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ballmore MOSOI tou If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Months June 2, Director 220-30-7296 1935 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Exen. The Toust Americal 1 ☐ Yes 2X No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 239 Funeral Tidyman Road 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify δ Specify: 3 Divorced 4 Divorced | Hygiene. other than "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Westinghouse Pages 1 and 2 should be filed vent of Health and Mental Hygident: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Norman S. Brown Anne Ecker1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. 239 Tidyman Road J. Peter Brach, Jr. Husband Reisterstown, MD 21136 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Carroll Cremation 11/10/08 Hampstead Maryland nature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** brain hemianon disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** hemorrhage subarachnoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course cal 29a. Certifier completely (Check only one) basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) November 9, 2008 -000 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of Mospital Year)

State Registrar Day,

KNOWA

Amend 29c,30,perDVR g885 11/12/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7 &8 per Fh 8885 11/12/08 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 12:45P M BEARMAN 2008 **JOSEPH** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 3307 MARNAT ROAD BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/31/1927 1**924** 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Days Country) Months 84 213-34-1241 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 3307 MARNAT ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WHOLESALE FABRIC OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BEARMAN SAMUEL GUSSIE UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 MARNAT ROAD, BALTIMORE, MD MONYA BEARMAN / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) B'NAI ISRAEL CONG. 11/09/2008 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 1000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Oase and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number D18095 29d. Date signed (Month, Day, Year)

Examiner certificate be executed burial-trans Box 68760, signed by the attending physician I be detached for use as the buria P.0. Division of Vital Records, has To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di To the within 2

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, Ite Medical Experient must be realled at

Physician /Medical

Baltimore, Maryland 21215-0036

10

Michael T. Rudikoff, 31. Date filed (Month, Day, Year) State Registrar 2008

30. Name and address of person who compl

use of death (Item 23a) (Type, Print) MD 4000 Old Court Rd. Suite 301 Baltimore, MD 21208 #82. Registrar's Signature

20182

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yes **Physician** LORE В **BRYNES** 8:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BROADMEAD COCKEYSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 09/25/1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F Days Hours Min. GERMANY Director 214-18-5657 88 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examinar must be not lifted 1 ☐ Yes 2 No Director MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 YORK ROAD, #204-A 21030 USÄ Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🌠 No If Yes, Give Year or Dates: WHITE ð Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>HOMEMAKER</u> OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be find and Mental F GUSTAV BRUNN BAER ပ BIANCA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health a item 27 is GLENN BRYNES / SON 1416 ARMACOST ROAD, PARKTON, MDpermit. Pages 1 a
Department of He
Important: If Item
any Injury or oth 20b. Place of Disposition (Name of cemetery crematory or other place)
MEMORIAL GARDENS 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/09/2008 FALLS CHURCH, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final 1/2 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-trans Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No o been signed by the should be detached 9 Unknown <u>ت</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform 2 1 No Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Danursing Home 5 Residence 6 Other (Specify) 2 **D**NO 1 Tes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 U atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License number

State Registrar

10

31. Date filed (Month, Day, Year) 1

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of rtificate o			•	giene Reg. No.	2008	35702
			Decedent's Name (First, Middle,	Last)	st)					2. Date of De	ath		3. Time of Death
	Physici /Medio		FRANCES				BOTWIN	ΙK		Novembe .	Day	Year 2008	1955 M
a delegan	Examin		4a. Facility Name (If not institution,	give street and number)	\		4b. City, Town	, or Location	n of Death	1	4c. C	County of Death	
pare?			Singi Hosp	ital of C		none	If Under 1 Yes	time	re ler 24 Hrs.	City		T 0 81 0	N/A
н	Funeral Director		5. Social Security Number 218-05-7648	. Sex 7. Ag 1 □ M 2 💢 F	e (<i>In yr</i> s. <i>I</i> a 90	<i>st birthday)</i> Yrs.	Months Day			8. Date of Bir Month Da 10/02	th 1/1 ^{Year)} 8	9. Birthp Cour	place (State or Foreign htry) MD
			Usual Residence of Decedent		- 50					10/02	7 1 3 1 0		110
	ryland		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	e Ma 8a-f s	Director	MD BALTI	MORE	В	ALTIM							1 □ Yes 2 🕅 No
	vith th	Dire	10e. Street and Number				10f. Zip Cod				10g. Citize	en of What Cour	-
	sath v	eral	2114 CHARLES H	12. Was Decedent	Ever in II S	12	Was Decedent	2120		posify Voc or No		4. Race - Americ	SA man Indian
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Evernine must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces?			Was Decedent of If Yes, specify C 1 □Yes 2X\N			o Rican, etc.)	1	Black, White,	
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Oc	cupation	nost of wor	kina	16b. Kind	d of Business/In	dustry
21	within 7 ene. than " ı	nple	Elementary/Secondary (0-12)	College (1-4or	ō+)	life.	kind of work do DO NOT use ret			ning		OUN	110.04
121	led w Hygiel Iher th		12 17. Father's Name (First, Middle, La	ot)			HUM	EMAKE		ne (First, Middle	Maidan S		HOME
Maryland	be d d	To Be	ABRAHAM	si <i>)</i>	G	OODMA	N	TO. IVIC	ANNA	ie (riist, middle	, waideri 3	WOLF	
lar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship									Town, State, Zip	
	s 1 and 2 of Health item 27 I		MARLENE WEINST 20a. Method of Disposition	OCK / DAUHO			18 NAVA			Date Date		D 2120 ation - City or To	
סר	ages nt of 1 :: If ite		1 X Burial 2 ☐ Cremation 3				nsition (Name of matory or other p		!			·	
Baltimore,	permit. Pages 'Department of B Important: If ite any Injury or of		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		RE		COB CON			9/2008 OL LEVI		KSBURG, & BROS.	
Ba	Depi Impo		> Scottill	. Cutter									MD 21208
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	mplications that cause ly one cause on each li	d the death. ne.	Do not en	ter the mode of	dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between
- Ale	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	eps	15							Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as	or as a contequence of):								
		<u>-</u>	Sequentially list conditions,	b									
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	31100 0171									
ć	exection and and rial-tra	Exa	resulting in death) Last	c Due to (or as	a conseque	ence of):							
8760,	cate be executed physician and the burial-transit	dical		d									
9		Medi	IF FEMALE:										
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	death 3	☐ Ectopic pregna ☐ Other (specify				23	3d. Date of delive Month	ery Day Year
о. С.	that ned b	by Pr	Part II. Other significant condition	s contributing to death b	ut not resul	ting in the u	nderlying cause	given in Pa	rt I.	23e. Did t	obacco us	e contribute to the	ne cause of death?
ğ	w requires that s been signed b should be det		Atrial F	-, brillat	04					1 🗆	Yes 2	No 3□ Prot	pably 4 ☐ Unknown
တ္ထ	e law re has bee le 2 sho	Completed	1-ange- 13	Cell L	ym	show	na			24a. Was		24b. Were auto	psy findings available
Ä	The I	, om	Herother	ardison	-					autoj perfo 1 □ Yes	ormed?	death?	mpletion of cause of
Vital Records,	ician: The certificate ector, pag	Be	25. Was case eferred to m-dical examiner?	6,0120				26. PI	ace of Dea	th (Check only o			
of \	Physician: this certific ral director, I	၉	1 Yes 2 No	Hospital: 1 Impati		<u></u>	IL S L DOM	Other: 4 🗆	Nursing H	ome 5 ☐ Resi	dence 6	☐ Other (Specif	ý)
'n	ling F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time o Injury	V	njury at Vork?		28d. Describe	how injury	occurred	
Sic	Attending If death. ector: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could no	be 200 Place of In	un - At hor	no form of		□Yes 2	∐No	20f Location /	Chrond n - d	Aborehouse Done	J. Davida Musebay
Division	lor A after Direct	Certification:	4 ☐ Homicide determine	building, el	c. (Specify)	eet, factory, offic	æ		City or To	wn, State)	Number or Hura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	edical C	(Check only 2 ☐ Medical Ex	Physician: To the best aminer: On the basis of	of examinati	/ledge, deat	h occurred at the	e time, date ny opinion,	and place	e, and due to the arred at the time.	cause(s) a	and manner as s	stated. o the cause(s)
	thin 2 the lot	Med	one) 29b. Signature and title of certifier	and manner st	ated.			ense numbo				signed (Month,	
	7 wit		Signal of the three times	Se.	ME		230. 210	-C	00	0			6,2008
	b.		30. Name and address of person when the same address of person when the same and address of person when the same address of person whe	no completed cause of	leath (Itom	23a) (Tuno	Print)	<u> </u>			NOV5	MOEL	6,400
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Ye ar **Physician** 0342 AM Denise Baker NOVEMBER ROCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SMINT AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Oct 3, 1959 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 ₩ F Mary land 49 Director 219-66-6756 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examinar must be notified at 1 √Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA 3040 Arunah Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: þ Specify: black 3 ₺ Widowed 4 □ Divorced Be Completed Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Thomas Baker Mary Elizabeth Dunn Edwards ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raven Boone/daughter 2625 Loyola Southway Baltimore, MD 212215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Want State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final disease or condition resulting in death) Physician Hemorrhagic HOURG /Medical Due to (or as a con equence of): Examiner DAYS pastrointestinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician a Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ It recreasion 2 No 3 Probably 4 Unknown 1 ☐ Yes MELLITUS certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an STAGE END autopsy 1 ☐Yes 2 ☑No director, 25. Was case referre medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To s after death.

I Director: After this
of in by the funeral di 27. Mann of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou₁ the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NO GMBER 720654 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sount 2122 BALTIMERE CATON AVENUE 32, Registrar's Signature State Registrar

Devise

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 45 OERI OUL 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 0 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/09/1931 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days **X**XM 2□ F Months Hours Mary I and 218-26-8000 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It would also in it in the institution. 1 □Yes 2√XNo Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 315 Ingleside Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

WAYES 2 No 56-161

Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify: White þ 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 17. Father's Name (First, Middle, Last)
Michael Boeri 18. Mother's Name (First, Middle, Maiden Surname) Mary Sparanzella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michele Boeri DTR 19 Inverin Circle Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State GreenMount Crematory 11/07/2008 | Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John O Mitchell IV Funeral Service of nature of Funeral Fervice Licenses unio Dulaney Valley PA 200 East Padonia Road Timonium Md 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 100 /Medical Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical the 1 for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 110 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 ____ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ___Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical or Lipcation of Death 4c. County of Death 4a. Facility Name (If not institution, give sireet and number) Examiner If Under 24 Hrs. N/A If Under 1 Year Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 219-32-4546 72 Director April 26 1936 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 10a. State 1 ☐ Yes 2 ☑ No Director Anne Arundel Maryland Brooklyn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be r 600 Holy Cross Road 21225 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Household 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Ritenour Mildred Harris ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Richards (son) 3501 Clarenell Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. Date 12 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Md 21122 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each in 23a. Par 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a minsequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending physical for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 4 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No To the Hospital or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) s after death.

I Director: After this ce id in by the funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours and
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

Amena

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's Signature

31. Date filed (Month) Day, Year) 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year :00 November ,2008 William Crusse 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death en ni Fnne Baltimore Washington Medical Center ISVIY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min 1 → M 2 □ F 80 MD 219-22-8725 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔼 No Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 USA 1904 North Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coil Gang Checker Bethlehem Steel 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Hartlove Frank William Crusse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 North Avenue Pasadena, MD 21122 Dorothy R. Crusse/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/2008 Veterans Cem Crownsville 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications the caused Physical part of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0~ 28 disease or condition resulting in death) (or as a c nsequence of): Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 25. Was case referred to medical examiner?

Physician /Medical Examiner

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Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar manages.

for use as the burial-tran

The law requires that the death certificate be executed

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Box (

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Division of Vital Records,

the Hospital or Attending Physician:

Examine Certification: To

Physician/Medical Completed by

Medical

Be

attending physician signed by the should be page 2 s this certificate ours after death.

eral Director: After this certific filled in by the funeral director,

within 2 State Registrar

DHMH 17 Rev 1/2001

24 hours

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

5 Pending investigation

6 ☐ Could not be

determined

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1- Inpatient 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) *Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital:

28a Dafe of Injury

(Month, Day,

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUR 30

Year) 31. Date filed (Month, Day,

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of De th

T Natural
2 ☐ Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year **Physician** 5:58 PM /Medical <u>Camilla Martellini Curran</u> Nov 6 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis HealthCare -The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/19/1928 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F Director 100-26-0464 80 Italy Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 No Director Calvert Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 610 Dutchman's Lane 21601 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Specify: White 3X Widowed 4 ☐ Divorced 'natural", Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Piero Martellini Maria Louisa Parravicino Garzoni ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Fletcher/Daughter 3308 Rosemary Lane, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 11/10/2008 | Hanover, Maryland 21. Signature of Funeral Service Licensee 21.076 Anatomy Gifts Registry (3/ 7522 Connelley Drive, Ste.P, Hanover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROWARY YEARS Due to (or as a consequence of): ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 18177 Due to (or as a consequence of) Examine FAILURE TO Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Uoknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2000 1 Yes 2 No

Physician /Medical **Examiner**

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

.la Curran Maryland 2121

amill,

timore,

Bai

Records, P.O. Box 68760,

Division or Vital

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician a s the burialhas been si e 2 should l Be Completed Certification: To neral Director:

26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PCS 2 ER/Outpatient 3 DOA

25. Was case referred to medical 1 Yes 2 **4** € 27. Manner of Death 1 atural

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

28b. Time of 28c. Injury at Work? Injury 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29a, Certifier

2 Accident

3 Suicide

4 Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month; Day, Year) 32 Registrar's Signature

610

DUTCHMANS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 09:15AM DANIEL CHMIELEWSKI 2008 NOV 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOS COLUMBIA HOWARD) TAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours 1 2 F 213-26-9583 78 Balt., 12/27/1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Fallston Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2407 Munford Drive 21047 America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify white 3√Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Columbia Vending Serv. 12 <u>Accountant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stefan Chmielewski Wanda Rupinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Munford Drive Kenneth A. Chmielewski/ son Fallston, Maryland 21047 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date November Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12, 2008 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) espiratory day Due to (or a consequence PTIC Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Yea Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Chronic obstru disease 1 ☐Yes 2 ☑No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation

Physician /Medical Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ihe Medical Exonings must be notified at

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

burial-trar attending physician Physician/Medical the as nse for signed by the a þ ficate has been sig r, page 2 should b Completed certificate

director,

this

hin 24 hours after death. the Funeral Director; A npletely filled in by the fu

within 2.

After this funeral c

Be

Certification: To

Medical

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MD, +CCf 29c. License number 36845

Nov. 09, 2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man-Cly Nguyen, MD, FCCP 31. Date filed (Month, Day, Year)

Registrar

NOV 12 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💚 🗋 🗎 Certificate of Death 1. Decedent's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Month Opear 10 06f M illiam **Physician** 6ti /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALTIMOR Andorra BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 8 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Months 1 M 2 □ F BACTIMORE, MC Yrs. 213-07-8040 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Neufect Examinan to anothed at 1 ☐ Yes 2 No Director DALTIMORE BALT MORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2123 SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Moves 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Whi Specify. 2 3 ☐ Widowed 4 ☐ Divorced Te Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'na any injury or other traumatic event, it a Waltoone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Masonra 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Dle မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE Eastford J Dertini-MD nephec Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 08 FOREST HILL MLD 4 □ Donation 5 □ Other (Specify) , BALTIMORE, MD Z1234 21. Signature of Funeral Service Licensee Evans Funeral Chapel+CREMATION SERVICES - BELAR Lyrota 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the detached 9 I Inknown signed by t 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No certificate Division of Vital fo the Hospital or Attending Physician: : After this certiflo funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DRIVE, / WES Open Buldy, 7505 Oslo, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALIKHAN 103A,

Registrar DHMH 17 Rev 1/2001

State

MAHM DOD

31. Date filed (Month, Day,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** November 8,2008 8:46P M Robert Dale Colebank /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 310 Burwood Avenue Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) July 27, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1∭XM 2□F 220-56-9089 55 Yrs. 1953 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show rthen "natural", or items 23a or 28a-f ehov the Medical Exemiter in ust be notified at MD Anne Arundel Glen Burnie 1 Yes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 310 Burwood Avenue 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Auto Mechanic Commercial Pages 1 and 2 should be filed w timent of Health and Mental Hygier tant: If Item 27 ie marked other ti jury or other traumatic event, Liu 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Dale Colebank Louise Shirley Stump 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Linda Ashburn/Sister 311 Gordon Avenue Severna Park MD 21146 Nov. 12, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Glen Haven Mem.Park 2008 Glen Burnie, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wellery 4 Physician DIR be res disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has autopsy performed? certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. s after death 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 11, 10, 2008 からろそとし MD

DHMH 17 Rev 1/2001

State

Registrar

Kunmi Majekodunmi M.D. 1406 South Crain Highway Suite 108 Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

12

31. Date fited (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NAVEMBER 6 2008 Caroline Comes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Deat Examiner Bouth more Oceshir neton Medical Guter Bunne If Unde 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foleign Country) Funeral 1□M 2 F Months Hours Min 217-19-0809 10/13/1928 Director MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b County traumatic event, the Medical Examiner must be notified at 1 ∏Yes 2X No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? "natural", or items 23a or 7355 E. Furnace Branch Rd. 21060 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Hentschel Maude Peddicord ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 239 Carroll Rd.; Glen Burnie, MD 21060 Mr. Herbert Comes / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, MD Meadowridge Memorial 11/10/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CHRISTA Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 2 1 ☐ Yes Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica director, 25. Was case referred medical examiner? 26. Place of Death Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 2 **□** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 27. Many r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital or within 24 hours at To the Funeral D 29a, Certifier t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

DHMH 17 Rev 1/2001

Box 68760,

P.O.

Division of Vital Records,

comes, sadie

State Registrar

31. Date filed (Month Day, Year) 32. Segistrar's Signature

pleted cause of death (Item 23a)

ame and address of person wh

29b. Signature and title of confiler

Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** George D. Cowie, Jr. 2, 2008 5:30 November Α /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 87 Director 579-18-0844 Oct. 29, 1921 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extraction to the context. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland | Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9228 Fall River Lane 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 2 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer Mechanical Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodora Hurlbut P George D. Cowie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine C. Cowie/Baughter 9228 Fall River Lane, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 🖾 Cremation 3 Removal from State Montgomery 9, 2008 4 ☐ Donation 5 ☐ Other (Specify) Cremătorium, Bethesda, Maryland Inc. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. ·M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ischemic Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsectioned of) Examiner The law requires that the death certificate be executed Diabetes Mellitus, Type 2 physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No s been signed by the should be detached Ö 9 I Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Chronic Obstructive Pulmonary Disease 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy certificate 1 ☐ Yes 2 ☐ No Vital 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To of 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division (Month, Day, Year) Injury 1 XNatural 5 Pending 1 □Yes 2 □No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified License number D37801 November 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Aimee Seidman MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

15020 Shady Grove Rd., Suite 300, Rockville, Maryland 20850

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	-	For State Registrar		State of M	aryiari			of Death		entarriy	Reg. No.	2008	35713	
Dharisis		Decedent's Name (Fit	irst, Middle, Las	t)						2. Date of De		Year	3. Time of Death	
Physicia /Medic		Mary		Costello						Vover	sher	7,200		
Examin	er	4a. Facility Name (If not	institution, give			41	o. City, Tow	n, or Location	n of Death	ه ا		South		
Funeral		5. Social Security Numb	er 6. Se		ge (In yrs.		Under 1 Y	ear If Und	er 24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. Bir	thplace (State or Foreign ountry)	
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or 28	Director	10e. Street and Number			4		10f. Zip Co	de		- 1	10g. Citiz	zen of What C		
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and 2 s atth ar 27 Is er trau		Colleen Pat	· ·	**		1213 N				eister			21136	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispositi		Removal from State	/	Place of Disposition cemetery, cremate	on (Name o	f place)		ate	20c. Lo	cation - City or	r Town, State	
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permi Depa Impo any ir		21. Signature of Funera	al Service Licen	2 lini				ddress of Fac NERAL	110			stown R own, MD		
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/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):	1 - 5 - 6		1 2	isea!				
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w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medic	Part II. Other significan	nt conditions o	ontributing to death b	out not res	ulting in the unde	rlying caus	e given in Par	rt I.	23e. Did	tobacco u	se contribute	to the cause of death?	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical C			yslcian: To the best niner: On the basis of and manner si	of examina									
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Sta Registr		31. Date filed (Month, D	V 1 2 20	108 Regist	rar's Signa		N.		/			1		

Examiner Social Security Number **Funeral** Director 100-12-1066 Usual Residence of Decedent 10b. County 28a-f show the Medical Examiner must be notified at Director Md. 10e. Street and Number , or items 23a or Funeral permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examire one. Baltimore, Maryland 21215-0036 ρ 3 X Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) Be Daniel Toohev ပ္ 20a. Method of Disposition Immediate Cause (Final **Physician**

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. cate has been signed by the a page 2 should be detached to Division of Vital Records, To the Funeral Director: After this certific completely filled in by the funeral director, death. within 24 hours a

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death_D NOVEMBER 7, **Physician** 2008 10:30 M Eileen Ε. Callahan /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Center Towson 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours 1 □ M 2 🗓 F New York 1923 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Baltimore Glen Arm 10g. Citizen of What Country? 10f. Zip Code 11630 Glen Arm Rd. #10G 21057 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Ye ar or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann McGowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon Grzanka/ Daughter 217 Farm Rd. Aberdeen, Md. 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 11-19-2008 Arlington, Va. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Juneral Service Licenses 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death END STAGE CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) Due to (or as a consequence of) DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NON-ST ELEVATION MYOCARDIAL INFARCTION 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No CONGESTIVE HEART FAILURE 24a. Was an autopsy performe 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 7601 OSLER DRIVE, TOWSON, BOON POH D. 32 egistrar's Signature 31. Date filed (Month, Day, Year) State NOV 12 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 8:35 AM M 7, 2008 November James E. Curtis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min 1°₩ M 2 F Yrs. 73 Director 08/13/1935 MD 218-30-4993 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 □ No Director MD Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 items 23a Funeral 20850-United States 1019 Neal Dr. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 'natural", or Specify: White 1 ☐ Yes 2 🗷 No Specify: ð 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Building Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental F is marked ott Be Mabel Elizabeth Oden ပ Clarence Everette Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Shirley C. Curtis/Wife 1019 Neal Dr. Rockville, MD 20850-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Nov 10 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00382 Rapp Funeral & Cremation Services Xohuman 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ventricular nucara disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed oronar physician and s the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2 No 1 □ Yes 2 🗆 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death.

I Director: After in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

VON

Virginia 31. Date tiled (Month, Day, Year)

Colliver

Colliver

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 6410 32. Registrar's Signature

the

Baltimore, Maryland 21215-0036

6410 ROCKYEDGE DR

29c. License number

200

BETHESDA MD

35716

Physician	l
/Medical	
Examiner	

Funeral Director

Division of Vital Records, P.O. Box 68760,<

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and "completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sta

	Registrar		Cer	inicate of	Deam		Reg. No.		00,			
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n il	James Elliott Co	ornell, Jr.				Novemb	er 8	3 2008 3	10:40 a ^M			
r	4a. Facility Name (If not institution, give si 8397 Montgomery Ru	ın Road, Unit	E	Ellic	r Location of Deatl ott City]	County of Death Howard				
	5. Social Security Number 6. Sex	7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birth Cou	place (State or Foreign intry)			
	770 34 7341	78	Yrs.	birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 4, 1930 9. Birth Cot FEB 4, 1930								
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era		2. Was Decedent Ever in U.S	S 13 W		Hispanic Origin? (S	necify Yes or No		14. Race - Ameri	ican Indian			
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2	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates: 195.	53	□Yes 2 No	Specify:			Specify: Whi	to			
ted	15. Decedent's Educa	ation	16a. Decede	ent's Usual Occup			16b. Kir	nd of Business/In				
Be Completed by Funeral Director	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	during most of wor d)	King		ington,	D.C.			
Ö	8	,	Mechan	ic			Gov	ernment				
e Re	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	e, Maiden S	Surname)				
0	James Elliott Corn	ell			Alva Ma	rie Mill	Ls					
	19a. Informant's Name/Relationship (Typ		,	,	and Number or Ru				p Code)			
	Ellen J. Carpenter		L		Rd Seve	rna Parl						
	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	20b. P	lace of Dispos emetery, crem	ition (Name of atory or other pla	ce)	Date	20c. Lo	cation - City or To	own, State			
	4 □ Donation 5 □ Other (Specify)	Met			Inc. 11/			imore, l	MD			
	21. Signature of Funeral Service Licensee	^e C. Todd Dri	ng C	Name and Addre	ess of Facility Society rick Rd	of Mary	zland	Inc				
_	(C TIM)		Ž	99 Frede	rick Rd	Baltimo	ce,MD	21228				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
I Onset and I												
	disease or condition resulting in death) a. CERHUSED CARCINOMATOS1S Due to (or as a consequence of):											
.	Immediate Cause (Final disease or condition resulting in death) a. CENERAUSED CARCINOMATOSTS Due to (or as a consequence of): ADVANCED WING CANCER Sequentially list conditions,											
ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
(am	Cause (Disease or Injury that initiated events c. Due to (or as a consequence of):											
<u> </u>	land the second	Due to (or as a consequ	ience or):									
g	d.											
₩ We	IF FEMALE: 23	Bc. If yes, outcome of pregna	ncv					10 L D - 1 1 L - 11				
ä	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3 🗆	Ectopic pregnand Other (specify) _	У	23d. Date of delivery Month Day Year						
Sign	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	eaui 5	Ottlet (specify) _								
=	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the und	derlying cause giv	en in Part I.	23e. Did	tobacco us	bacco use contribute to the cause of death?				
5						10	Yes 2	No 3√ Pro	bably 4 🗆 Unknown			
ete						24a. Was	an .	24h Were auto	oney findings available			
ᇍ		psy ormed?	sy prior to completion of cause of									
3	25. Was case referred to medical 26. Place of Death (Check only one)											
ň	examiner? 1 ☐ Yes 2 ☑ No		Other (Speci	56.0								
-	27. Manner of Death	1 Inpatient 2 28a. Date of Injury	28b. Time of	28c. Inju Wor		28d. Describe		(-7	19)			
910	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		k? Yes 2 □No							
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location	(Street and	d Number or Run	al Route Number,			
Due to (or as a consequence of): Comparison Comparis												
								stated.				
								o the cause(s)				
								8				
	30. Name and address of person who con	•		,								
	CHO MANNE, MD			RD #.	301 C	ATONS	VILL	EN	(D 21778			
9	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	ache)								

Registra

State of Maryland / Department of Health and Mental Hygiene

35717

		•	For State Registrar		State of W	ai yiaii		rtifica					eg. No.	008	35/11	
	Physicia	an	1. Decedent's Name (F	First, Middle, Las								2. Date of Deat Month	th Day	Year	3. Time of Death	
	/Medic		Janine	Evett				41. 01.	T			Novembe:		2008	2:10 p ^M	
	Examin	er	4a. Facility Name (If no Manor Ca	_		,			tom;	Location of	oi Death			ounty of Death ntgome	rv	
	Funeral		5. Social Security Num	ber 6. Se		ge (In yrs.	last birthday		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign	
	Director		125-64-3020 Usual Residence of De)		42	Yrs.		Luye	710410		APR 4,	1966	New	York	
	/land			b. County		10c. Cit	y, Town or L	ocation						1	0d. Inside City Limits	
	a-fsh	ctor	MD Me	ontgomer	y	Gen	nantov	m							1 □Yes 2 XNo	
	ith th	Dire	10e. Street and Number		•				p Code			1		g. Citizen of What Country?		
	eath v	Funeral Director	21247 Buny	yan Circ	12. Was Decedent	Ever in U.	S. 13.	208 Was Dece		ispanic Or	igin? (Spe	ecify Yes or No-	US/	A Race - Ameri	can Indian.	
9	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it s in sidel Experiencement.	Fun	1 X Never Married	2 Married	Armed Forces 1 ∐Yes 2 X If Yes, Give	?				n, Mexicar Specify:		to Rican, etc.) Black, Whit				
21215-0036	ural",	Completed by	3 ☐ Widowed 4 ☐		Year or Dates:		16a. Decedent's Usual Occupation (Give kind of work done during mo.							Blac		
-5	in 72 h "natu	olete	(Specify	Decedent's Ed	de completed)				durina mos			16b. Kind	l of Business/In	dustry		
212	d withi	mo	Elementary/Seconda	ary (0-12)	College (1-4or	5+)	Accou						Accou	unting		
nd	be filed Ital Hy Ital othe event,	Be C	17. Father's Name (Fir.								_	(First, Middle, I	Maiden St	urname)		
yla	should be ind Mental i marked o	2	James E. (Rayna C					*				
Maryland			19a. Informant's Name Rayna Clay										Code)			
J.e.	of Hear		20a. Method of Dispos			20b. F	lace of Disperent	osition (Na	me of other place	e)	D	ate	20c. Loca	ation - City or To	own, State	
ij	Pages tment of I tant: If ite jury or o		1 □ Burial 2 L X C 4 □ Donation 5 [Removal from State)	Metro Crematory, Inc. 11/1							D			
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra once.		21. Signature of Funer	al Service Licen	C. Tod	d Dri	ng	Crema 299 F	rede	Soci Soci rick	ety o	of Maryl	land,	Inc. 21228		
			23a. Part 1. Enter the c shock, or heart fa	disease, or compailure. List only o	lications that cause one cause on each l	d the death	n. Do not er	nter the mo	de of dyir	ng, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death	
San San	Physician		Immediate Cause (Fin disease or condition resulting in death)	ai	a	VIC	ical	Car	nu	· - E	Adv	anud	,		Offiser and Death	
1	/Medical Examiner		recurring in dodary		Due to (or as	a conseq	uence of):									
	, , ,	ner	cause. Enter Underlyin Cause (Disease or injuthat initiated events	ions,	b. Due to (or as	s a consequ	uence of):									
	ecuted and transi	Examiner	Cause (Disease or injuthat initiated events resulting in death) Last	iry												
68760,	rificate be executed ng physician and as the burial-transit	e E	resulting in death, East		Due to (or as	s a consequ	uence or):									
687	ifficate g phys as the	ledic			d								-1			
Вох	th cert tendin	an/M	IF FEMALE: 23b. Was decedent pro		23c. If yes, outcome 1 ☐ Live birth								23	d. Date of deliv		
P.O. E	Physician: The law requires that the death ce this certificate has been signed by the attendired director, page 2 should be detached for use	Physician/Medical	in the past 12 mo 1 ☐ Yes 2 ☐ 🗓 9 ☐ Unknown		4 ☐ Pregnant 9 ☐ Unknown			Other (s						Month	Day Year	
	that the	Ph/	Part II. Other significa	nt conditions co	ontributing to death t	out not resi	ulting in the	underlying	cause giv	en in Part I		23e. Did to	bacco use	contribute to t	he cause of death?	
rds	quires an sigr uld be	ed by										1 □ Ye	es 2 🗆	No 3□ Pro	bably 4 12 Unknown	
eco	law re as be 2 sho	Completed										24a. Was a		24b. Were auto	ppsy findings available ompletion of cause of	
<u>س</u>	: The cate h	Con										perfori	med? 2 DHo	death? 1 □ Yes	·	
Vita	siclan certifi rector	Be	25. Was case referred examiner?	ŀ	Hospital:				OA Oth	er.	•	(Check only on				
of	g Physer this eral di	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	- Telle	1 ☐ Inpat	ury	ER/Outpation 28b. Time		OA 28c. Injur Worl	445\NI		me_5 ☐ Reside 28d. Describe ho			fy)	
ion	ending aath. or: Aft he fun	atio	2 Accident	5 ☐ Pending Investigation	(Month, D	ay, rear)	Injury	M		Yes 2	No					
Division of Vital Records,	or Atter tifter de Directo	Certification:	3 ☐ Suicide 4 ☐ Hornicide	6 Could not be determined	28e. Place of In	jury - At ho tc. <i>(Specif</i>	ome, farm, st	reet, factor	y, office		2	28f. Location (S: City or Town	treet and i n, State)	Number or Run	al Route Number,	
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 12 (Check only 2	Certifying Ph	ysician: To the best	of my kno	wledge, dea	th occurre	d at the ti	ne, date a	nd place,	and due to the d	ause(s) a	and manner as	stated.	
	the H hin 24 the Fi	Medical	one)		iner: On the basis and manner s	tated.	and/of I				an occurr					
	Vwit Cor	<	29b. Signature and title	e of certifier	29					e number	66	2	19d. Date	signed (Month,	∪ay, rear)	
	L		30. Name and address	of person who	ompleted cause of	death (Iten	n 23a) (Type			, -	· ·		11/10	100		
	-		Sunitha	Bhoga	ville, 98	rol C	neo na		~ NU	4 4	1-17	Silve	2750	ling s	nD20902.	
	Sta Registr		31. Date filed (Month, I	Day, Year)	32 Regist	rar's Signa	ture	- 10 E		,		,	4	1,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:26 AM rowe 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Frostburg Nursing and Rohab Ctr Allegan trostoura MD 8. Date of Birth (Month, Day, Year) FEb 2, 1921 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Min Days Hours 1 ☐ M 2 🛛 F Maryland 87 213-12-9625 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2√∑ No MD Allegany Frostburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 158 McCulloh Street 21532 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Michael Piper Sr Idella Mae Leake ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 156 McCulloh Street Frostburg, MD Tim Crowe/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21201 Baltimore. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consiquence of): month disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Be (

Certification: To ours after death.

Medical

					24a. Was an autopsy performed? 1□ Yes 2★ No	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 2 No
25.	Was case referred to medical			26. Place of Dea	th (Check only one)	-
	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [OOA Other: 4 Nursing H	ome 5 Residence 6	□Other (Specify)
27.	Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	

3 ☐ Suicide 6 Could not be 4 Homicide

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier workochesh

NOV 12

00055325

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

and manner stated

WALSH RD Lumberland MD21502 MD 425 WONSOCK SHIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

After

within 24 hours a To the Funeral I

			1 - State of Marylar Registrar		artment of Health and N rtificate of Death	•	27% 27% 27%	8 35719
Ī	Physicia		1. Decedent's Name (First, Middle, Last) JOHN	CRAV	1FORD	2. Date of Dea Month	Day Yea	3. Time of Death 9:38 PM
)	/Medio Examin Funeral		4a. Facility Name (If not institution, give street and number) +RINCE GEORGE'S +HOSPITAL 5. Social Security Number 6. Sex 1 M 2 □ F 86	CTR	4b. City, Town, or Location of Death HEVERLY If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		4c. County of De	
	e Maryland Sa-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	•	12-	B'-21	10d. Inside City Limits 1 □Yes 2 ☑ No
	3a or 28	al Director	10e. Street and Number 2425 25th Street SE		10f. Zip Code 20020		10g. Citizen of What USA	•
9800	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, Ira Redical Examinar must be rediffed at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	unk '	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: b	
Maryland 21215-0036	d within 72 hegiene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) unk College (1-4or 5+) unk	16a. Deced (Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	unk _{ing}	16b, Kind of Busines	ss/Industry unk
land	ed and a second	To Be C	17. Father's Name (First, Middle, Last)		unk 18. Mother's Nam	e (First, Middle,	Maiden Surname)	unk
	s 1 and 2 s of Health ar item 27 is other trau		19a. Informant's Name/Relationship (Type. Print) Prince George's Hospital Cente	1	ng Address (Street and Number or Run 1 Hospital Drive (
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State	Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date	20c. Location - City	or Town, State
Ball	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral St. e. Licensee de, li récto		Name and Address of Facility and altimore, MD 21201	655 W.	Baltimore	Street
	Physician /Medical	F (0)	23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	th. Do not ent	er the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		CARDIOVASCULA	R DI	SEASE	
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consected)					
	7 20 8	Medi	IF FEMALE:					
O. Box	requires that the death certific leen signed by the attending p nould be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of pr	aldeath 3	Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year
Records, P.	w requires that the de s been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not res	sulting in the ur	nderlying cause given in Part i.			to the cause of death? Probably 4 Unknown
Hec	The law ate has b page 2 st	Completed				24a. Was autop perfo 1 □Yes	rmed2 prior to death	autopsy findings available o completion of cause of ?
>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 N	ER/Outpatier	26. Place of Deat		ne) dence 6 □ Other (S	necifu)
_	Attending Phir death. ector: After thiby the funeral	ation: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury			now injury occurred	<i>Secury)</i>
DIVISION	5 # E C	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At homicide determined building, etc. (Special Special	iome, farm, stro	eet, factory, office	28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	owledge, deatl ation and/or in	h occurred at the time, date and place vestigation, in my opinion, death occur	, and due to the rred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
			30. Name and address of person who completed cause of death (Ite OPHNELI CUMBERBATCH	m 23a) (Type,	Print) Print) Print) Print)	2 /	HEVERLY	/ US MD 20185
Ì	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 2 2008 32 Registrar's Sign	ature	while			

The law requires that the death certificate be executed Records. Division or Vital To the Hospital or Attending Physician:

certificate

After

Director:

hours after death.

within 24 hours at To the Funeral D

completely

Be

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Certification:

Medical

Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ▶6 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Mannel of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 🗌 Yes 2∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 11/10

Walsham Woods Road.

5:11

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Mary Land

 \mathbf{p}^{M}

State

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** $\boldsymbol{a}^{\mathsf{M}}$ Bruce G. Donning 2008 01:20 11 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 8214 Cypress Mill Road Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Min. 08/11/1930 Michigan 1 X M 2 □ F 78 Director 377-26-1366 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 U.S.A. 8214 Cypress Mill Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □No If Yes, Give KOrea Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or ite ury or other traumatic event, the Medical Examina 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas & Electric Budget Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel A. Beedon ပ George W. Donning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8214 Cypress Mill Road, Baltimore, MD 21236 Helen Donning, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. 11/10/2008 Hamostead Cemetery Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, INc. 21. Signature of Funeral Service Licensee Sarbracell 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MYEWID disease or condition resulting in death) UTE /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for es a consecuence of: Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š DISEASE icate has been significated by page 2 should b 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? AROTI autopsy performed? Yes 2 No After this certificate 1 ∐Yes 2 XV0 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P 1 Natural
2 Accident Injury 5 Pending a after death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/2008 D0057450 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVANA 22 SOUTH GREENE STREET, BALTIMORE MARYLAUD 21201 601 \$32. Registrar's Signature 31. Date filed (Month, Day, Year) State MOV 12 2008 Registrar

			■ State	and / Department of Health and N Certificate of Death		- 211118 35177
			Registrar 1. Decedent's Name (First, Middle, Last)	λ	Reg. 2. Date of Death	3. Time of Death
	Physicia /Medic		Kosalie	DANIECKI	NOV. 3	Day 2008 11:55 P. M
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death BALTIMORE
	Funeral			rs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign
	Director		219-10-6199 10M 2191F	Yrs. Months Days Hours Min.	1/29/192	4 BALTIMORE, MA
	/land		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location		10d. Inside City Limits
	e Mar) Ba-f sh Life d	ctor	MD Harford.	FOREST Hil	/	1 □Yes 2 No
	vith th	Director	10e. Street and Number	FOREST H.1	10g.	Citizen of What Country?
	ns 23	eral	11, Marital Status 12. Was Decedent Ever in	t - 1 - 1	pecify Yes or No-	14. Race - American Indian,
9	after o	/ Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities and be neithed at once.	Completed by Funeral	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	16a. Decedent's Usual Occupation	16h	Specify: Whi'te. Kind of Business/Industry
215	anin 72 9. In "na"	plet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	. Kind of business/moustry
21	ed with ygiene her tha t, the	Com	13	Homemaker		WN Home.
Maryland	intal H ed oth	Be	17. Father's Name (First, Middle, Last) An thony Rutkow		e (First, Middle, Maid	len Surname)
aryl	should and Me mark mark	욘	19a. Informant's Name/Relatio hip (Type. Print)	19b. Mailing Address (Street and Number or Rui	ral Route N er, Cit	ty or Town, State, Zip Code)
Ž,	and 2 ealth a n 27 is er trai	ľ	Thaddeus DANIECKIJR- Son	3603 Mylady's View	Ct. Mo	Ucton MD 21/11
Baltimore,	Pages 1 ment of Hi ant: If iten ury or oth		20a. Method of Disposition 20th 1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, crematory or other place)	1	Location - City or Town, State
Ħ	nit. Pa artmer ortant: injury	ľ	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Air Memorial Grandens 1/11 22. Name and Address of Facility 3. New Door of Facility	10Y 13	elAr, mD
Ba	permit Depar Impor any in	- 13	Home best to la Suchotus	Evans Fun exalchas	1+COESISTII	TON SELVICES - ROLAIR
			23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause or each line.	eath. Do not enter the mode of dying, such as cardiac		Approximate Interval Between
	hysician		Immediate Cause (Firm disease or condition resulting in death)	VE HEART FAILURE		Onset and Death
r.d	/Medical Examiner		Due to (or as a cons	equence of):		
	Do I +	ner	Sequentially list conditions, if any, leading to immediate cause Fater I Indexident	equence of):		
	and transi	Examiner	duy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	- A		
8760,	physician and the burial-transit		Due to (or as a cons	equence or):		
		ledical	d			
Вох	The law requires that the death certific tate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ F			23d. Date of delivery Month Day Year
0	the dea	ysici	1 Yes 2 No 4 Pregnant at time of 9 Unknown	of death 5 Other (specify)		Month Day real
о. С.	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
ords.	equire	ted b			1 ☐ Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	e law n has be e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ta	ding Physician: The n After this certificate h. funeral director, page	e Co	25. Was case referred to medical		performed 1 □Yes 2 🖼	death? No 1 Yes 2 No
<u> </u>	hysicia this cert al directo	m	examiner?	Othor	th <i>(Check only one)</i> ome 5 ☐ Residence	6 Nother (Specify) HOSPICE
0	Sing Pt J. After th funeral	L:io	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year,	28b. Time of 28c. Injury at Work?	28d. Describe how in	
isio	ten leath for: the	licati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - At	M 1 ☐ Yes 2 ☐ No home, farm, street, factory, office	28f Location (Street	and Number or Rural Route Number,
2	al or A s after al Dire ed in b	Certification: To	4 ☐ Homicide determined building, etc. (Spe	cify)	City or Town, St	ate)
	to the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to		(Check only 2 Medical Examiner: On the basis of exam	nowledge, death occurred at the time, date and place, ination and/or investigation, in my opinion, death occur		
	Io the t within 2 To the I complet	Medical	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	- s F 0		1 STANGELINP	R149797_		1/10/08
	10		30. Name and address of person who completed cause of death (I	em 23a) (Type, Print)	<i>(</i>	11 11 21 -2
			JACKIE JUNES CRN 231. Date filed (Month, Day, Year) 32. Registrate Sign	500 DULANEY VALLEY RU	7 Manla	M, MD 21093
	Star Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Sig	The same of the sa		

NOVEMBER 5,2008

DANIECKI

ROSAUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	,	Certi	ficate of	Death			Reg.	No. Zi	108 35/2.
Physicia	ın/	1. Decedent's Name (First, Middle,La	st)					2. D	ate of Death Ionth D Ovember 6	Day Year	3. Time of Death 1149 hrs
Medical Exami		SABINA 4a. Facility Name (if not institution, gir	o etreet and number)		La!	DOR D. City, Town, o			ovember 6	4c. County of	
		Sinai Hospital	e street and number)		1	Baltimore	5/ 200ation of	Death		To: County of	N/A
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last	birthday)	If Under 1 Ye	ear If Under	24Hrs. 8.	Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign
Director		116-18-8529	м 2ХГ	80	Yrs.	Months Da	ays Hours	Min.	04/24/	1928	POLAND
		Usual Residence of Decedent	·	40 - Oit - T-	own or Location						10d. Inside City Limits
ow any		10a. State 10b. County		• /		n					1 X Yes 2 No
Maryland 28a-f show 1 at once.	횴	MD N/A 10e. Street and Number		DAL	TIMORE	10f. Zip Code			1 10a	. Citizen of Wha	/1
ne Mau or 28	Director	6350 RED CEDAR	DIACE #2	nn		р	2120	a			USA
with the 1s 23a oe noti		11. Marital Status	12. Was Decedent			Decedent of H	lispanic Origi	in? (Specify			American Indian, Black,
death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, e									
s after ral", o	by	3 Widowed 4 Divorced If Yes Give Yeer 1 Yes 2 No specify:							Specify:	WHITE	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	ted	Elementary/Secondary (0-12)	College (1-4 or 5	,		s osual occup st of working li			done	6b. Kind of Busi	mess/maustry
0036 within 72 iene. er than	Completed	Liomontally/cocondally (o 12)	2			L	AB TEC	HNICI	AN		MEDICINE
5-0(led wi Hygien other		17. Father's Name (First, Middle, Las)				18.Mother's	s Name (Fir	st, Middle, Ma	iden Surname)	
21215-0036 hould be filed within 7 dd Mental Hygiene. is marked other than tife event, the Medica	o Be	ABRAHAM 19a. Informant's Name/Relationship (Your Delient	E	BESSEN	0.44 (0)		GINA	Davida Niverb	Cib. as Taura	WEISS , State, Zip Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f shaumatic event, the Medical Examiner must be notified at once	۲	WALTER DORN /	**								RE, MD 21209
- p = = =	1	20a. Method of Disposition	_		ce of Disposi	tion (Name of	cemetery,	Da			City or Town, State
Baltimore, bermit. Pages I an Department of Hea important: If iter		1 X Burial 2 Cremation 3 4 Donation 5 Other Specific		te CH	ŔŢŢŊĠŢ	00 (ace) 10 NO CO	NG	11/09	/2008	BALTI	MORE, MD
Baltimo permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Lice		, 1 011.	22. N	ame and Addre	ess of Facility	SOL	LEVINS	ON & BR	OS., INC.
യ 50 11		Kolub/ J			890	0 REIS	TERSTO	WN RO	AD - P	IKESVIL	LE, MD 21208
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	ach line.	the death. D	o not enter th	e mode of dyir	ig, such as ca	ardiac or res	piratory arres	t, snock, or near	Approximate Interval Between Onset and Death
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries Due to (or as a conse	rauence of):							Deau
		Sequentially list conditions,		19001100 017							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):							
/ _ =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):		_					
760, icate be executed physician and the burial - transit											
ial	/Medical	UNPENDED	AMENDED	-						23d. Date of	la Guna
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	ne or pregna		al death	3 Ectopic	pregnancy		Month Month	Day Year
Box 68's death certiff the attending ed for use as it	Physician	1 Yes 2 No 9 Unknow	4 Pregnant at	time of deat	h 5 Oth	er (Specify)				1	
D.O. By that the de ned by the detached f	Phy	Part II. Other significant conditions		but not res	ulting in the u	nderlying caus	e given in Par	rt I.	23e. Did tob	acco use contrit	oute to the cause of death?
P.O es that t iigned by	ξ								1 Yes	2 🗸 No 3	Probably 4 Unknown
cords, Plaw requires thas been sign 2 should be considered.	ete								24a. Was ar		Vere autopsy findings available rior to completion of cause of
of Vital Records, ng Physician: The law require After this certificate has been si neral director, page 2 should b	Completed			-					perform 1 Yes 2	ned? de	eath?
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Vit;	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	t-man-	R/Outpatient		Other ₄	Nursing H		tesidence 6	Other:
1 of Iing P		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day.Y Nov 6, 2008		28b. Time of Ir 1116 hrs	, ,	njury at Workî Yes 2 ✔	lDri		ow injury occurre uto collision	
SiOI Attended death	cati	2 Accident 5 Pending Investiga			24				Location (St	reet and Numbe	er or Rural Route Number, City
Division tal or Attendi as after death.	Certification:	3 Suicide 6 Could no determin	t be			it, lactory, offic	e ballarily, etc	1.0	or Town, Sta	ate)	vay Road, Pikesville, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physi	cian: To the best of m	v knowledge	, death occur	ed at the time	, date and pla	ice, and due	to the cause	(s) and manner	as stated.
Fo the vithin Fo the	Medical	one) 2 Medical Examin	er:On the basis of exa and manner stated.	mination and	l/or investigat			curred at the	e time, date a		
	Σ	29b. Signature and title of certifier		1			ense number			29d. Date signe November	od (Month, Day, Year)
		lalin	111	20th /# == 3	-P(O.IVI. E.				7, 2000
12		30. Name and address of person who Zabiullah Ali, M.D. Ass	sistant Medical E	•		n Street, B	altimore, N	MD 2120	1		
S	ate	31. Date filed (Month, Day, Year)	2. Registra	r's Signature	house	7					
Regis	frar	NOV 1 2 200	8 Alexander	SEL COLONS	San Marie and San						

1. Decedent's Name (First, Middle, Last)

burial-1 Box 68760. P.O. | signed by the a Division of Vital Records, certificate has be rector, page 2 sl this

Registrar DHMH 17 Rev 1/2001

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Renaissance Gardens If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day) Months Days Hours Min 1 X M 2 □ F 8 92 1916 April 213-38-3512 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evanither must be mutified at Silver Spring Maryland Montgomery 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 20904 Funeral 3160 Gracefield Road #1303 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the madeal Evandor in the factor of the proper. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 No If Yes, Give 1954 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ð Specify: Specify: White 3 Nidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Own Practice Dentist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Anna Stockburger ပ Adolph Dorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO Box 40, Lovettsville, VA 20180 Jacqueline M. Paul/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 12, 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. Sutter M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** demention hein /Medical Due to (or as a consequence of) Examiner Dertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗔 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 THNatural 1 ☐ Yes 2 ☐ No ieral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D59524 November 7,2008 humane Veen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVERN J. PUTHOMAND, 3110 GRACEFIELD ROAD, SILVERSPRING, MD 20904 01 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 100

2. Date of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes

2 No

1 ☐ Yes 2 No

New York

2008

0=200A

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 12:15 A^M NOVEMBER 7, 2008 ELKINS RHONDA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER S. Date of Birth Sept. 16, 1936 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1 ☐ M 2 🟋 F Months Days Hours 72 218-32-5764 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 →No Bel Air Harford Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 US 502 Lee Way Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify. If Yes, Give Year or Dates: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygid Important; If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gwendolyn L. Nunnelly Frank L. Berlinicke ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Lee Way, Bel Air, Maryland George Elkins (spouse) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory 11/08/2008 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Ait 21. Signatur of Funeral Service 21014 610 W. MacPhail Road, Bel Air, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) come Due to (or as a onsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) I□Yes 2□No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ↑ No 24a. Was an autopsy performed? Yes 2 No 2 No 1☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 | No Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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DAVID DUNN

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the

Division or Vital Records, P.O. Box 68760,

show

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

Williams.

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BEL AIR, MD.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 2323 PM E1za Sr. David Τ., NOU 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES TRZOH ALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo April 4, Birthplace (State or Foreign Country)
 TTT 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1932 Min. 1 X M 2 □ F 76 233-52-4877 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7.1s marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD Baltimore City Baltimore 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1917 Frederick Ave. 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\overline{\text{X}}\) Yes 2 \(\overline{\text{N}}\) No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

any Injury or Attach 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio white Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Brakeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eldon. E1za Mvrt1e (unkn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Elza Jr. / son 6508 Deep Run Pkwy, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/10/2008 Metro Crematory Catonsville MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA M01364 Glen Burnie MD 21061 421 Crain Hwy SE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Due to (or as a consequence of): CLZA VID NVID or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 dunknown cate has been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No this certificate 2 No 1 ☐ Yes 1☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 📹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar TIHO

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Date filed (Month, Day, Year)

aun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

DHMH 17 Rev 1/2001

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BALTIMORE MD-21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Vember **Physician** ESTES-MORRIS CATHERINE MARIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗶 F Yrs. JUNE 4, 1958 DC Director 578-78-1299 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 X Yes 2 □ No **Funeral Director** PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20721 USA 2005 WOODSHADE CT 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Be Completed by BLACK 3 ☐ Widowed 4 🛛 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) OLLIE MAE SLAUGHTER JOHN A. ESTES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12105 HURDLEFORD CT BOWIE. MD 20721 RACHELLE IJEOMAH / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 11-13-2008 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD e of Funeral Se SUITLAND, MD 20746 DONALD R. GRAY 4308 SUITLAND ROAD hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or con shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) ins **Physician** /Medical Due to (or as a consequence of) wo Crow cos Examiner a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 ☐Yes 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🐪 🗥 6 1 hpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manne eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 / Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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Pages 1 and 2 should be filed within 72 hours after

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Physician: The law requires that the death certificate be executed

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Division of Vital Records,

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29b. Signature and title of certifie

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31. Date filed (Month, Day, Year)

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2008

30. Name and address of person who completed cause of dea 14 em 23a) (Type, Print)

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32. Registrar's Signature

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Saltimore, Maryland

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its if offer a seminer must be notified at

Registrar

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

polis Rd., Suita 210, Lanham, MD. 20706

Amend #11, perFH G885 11/12/08 TI Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November **Physician** Scar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 2/21/1944 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** RUSS IA 64 214-94-3163 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County HALLANDALE 1 ☐ Yes 2 ☐ No **BROWARD** FL Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 33009 <u> 1920 S. OCEAN DRIVE,#18D</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married WHITE 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify Specify: þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) DENTISTRY DENTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REYZEL **JOSEPH** ZEYTMAN ည 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1920 S. OCEAN DRIVE, #18D HALLANDALE, FL 33009 EMILY ZEYTMAN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 Cremation 3 Removal from State 11/9/2008 HAR SINAI OWINGS MILLS, MD 4 Donation 5 Cher (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final espirator **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d by the attending physician and detached for use as the bunal-transit The law requires that the death certificate be executed Physician/Medical Box 68760 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ပ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F s after death. I Director: After t 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 🗌 Homicide Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES OOC 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Helen 31. Date filed (Month, Day, Year) State NOV 12 GOOG 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 9. 10 PM 200 OVER Anthony A. Ferrante /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALTIMOI n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/16/1920 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1**½** M 2□ F Maryland 88 214-18-6792 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 1 □Yes 2X No Funeral Director MD Baltimore Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21229 902 Beechfield Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Linotype Operator Printing 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Ferrante Francesca Onorato ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alice M. Ferrante / Wife 902 Beechfield Avenue, Baltimore, Maryland 21229
ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once. Md. Veterans Cemetery 11/12/2008 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final in Kneu **Physician** active oru 2(0) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence off Physician/Medical Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) Ö ed by the a 9 I Inknown 9 ☐ Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral branch. death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. egistrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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ORIGINAL

			For State Registrar	State of Marylar		rtificate of		-	ene g. No. 2008	35730
П	Physicia		Decedent's Name (First, Middle, La: Gerard	Harold	H.	'eldman		2. Date of Death Month November 9	Day Year	3. Time of Death
1000	/Medic Examin		4a. Facility Name (If not institution, giv				r Location of Death	novemen 9	4c. County of Deat	7:00 A ^M
and the			2221 Lodge Farm Road			Edgeme			Baltimore	
	Funeral Director		030-20-0324	1.2	last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 4,	^{Year)} 1938 9. Birt Co New	hplace (State or Foreign untry) York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	e Maryl 3a-f sho	ctor	Maryland Baltimo	ore	Perry	Hall				1 □Yes 2 No
	th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 5 Brook Farm Court	Unit 5F		10f. Zip Code 211	28	10	g. Citizen of What Co USA	untry?
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15-("natu	lete	15. Decedent's Ec (Specify only highest gra	lucation ide completed)	16a. Dece	dent's Usual Occup kind of work done	oation during most of work d)	ing 1	6b. Kind of Business/	Industry
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	ges 1 and 2 should nt of Health and Mei If item 27 is marke or other traumatic	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M	aiden Surname)	
yla		2	Morris M. Feldman		1		Raenell			
, Maryland			19a. Informant's Name/Relationship (Linda Rodgers	Friend	5 Bro	ok Farm (Court, Un	it 5F, Pe	City or Town, State, 2 erry Hall,	MD. 21128
Baltimore,			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	memoval from State	Place of Dispo cemetery, cren red Hear	sition (Name of natory or other place t Of Mary (Novem 12, 2	wer	oc. Location - City or Dundalk, MA1	
Ball	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Licer	Connell					ndalk,P.A. ndalk,Md.	21222
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ACTIC Due to (or as a consec		20515				
	Examiner			META STA	177C	PANCRE	ani A	DENOCAL	CLINOMA	12 MOS
7	sit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consec	juence of):	, .				
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ds, P.	uires that the de signed by the a ld be detached f	ρ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
SCO	law requir as been s 2 should	plete						24a. Was an	24b. Were au	itopsy findings available
= B	The law cate has page 2 s	Completed						autopsy perform 1 □ Yes 2⁵	ed2 death?	completion of cause of 2 No
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o	Attending Physician: r death. ector: After this certific by the funeral director,	5.	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of		4 Li Nursing Ho	ome 5 Resider		cify) HOSTIC =-
ion	ath. ath. rr: Afte	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	M 1 🗆	k̃? Yes 2 □ No			
Division of Vital Records,	al or Atter after de l Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deatl ation and/or in	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
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	^		William	a. Mi Aun	Le rel	D16	0801		10 NOV	2008
	1		30. Name and address of person who ILLIAM 31. Date filed (Month, Day, Year) NOV I 2	completed cause of death (Iter	m 23a) (Type,	MD 91	103 Fran	klin 5q	une Dr.	Balto MI
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2008 32. Registrar's Signa	ature	parti		¥		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SMEND MATMERS DEPARTMENT OF HEART 200 Methal Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day FRANCIS DONNA MARIE NOVEMBER 6, 2008 2055 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex 1 □ M 2 🗓 F Months Days Hours Min. 60 SEPT 20, 1948 DC 577-66-9083 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No CAPITOL HEIGHTS PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA 4316 URN STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US CENSUS BUREAU STATITICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARENCE DOUGLAS ANNIE MARIE DIXON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HARRY FRANCIS / HUSBAND CAPITOL HEIGHTS, MD 20743 4316 URN STREET 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 11-15-2008 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD of Funeral Service Licer SUITLAND, MD 20746 4308 SUITLAND ROAD DONALD R. GRAY plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): ACUTE MI Due to (or as a consequence of): Due to (or as a consequence of): . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2█ No

Physician /Medical Examiner

Physician

/Medical

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MD

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Funeral

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Completed

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mertical Evamina.

Baltimore, Maryland 21215-0036

Box 68760

Division or Vital Records, P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran the attending physician and signed by to After after death in by the

within 24 hours a

To the Funeral L State

Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗓 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> END STAGE RENAL FAILURE Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D45471

DHMH 17 Rev 1/2001

30. Name and address of

YEHEYIS 'f.

31. Date filed (Month, Day, Year)

person who

NECUSSIE

TAKOMA PARK, MD

20912

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

7600 CARROLL AVENUE

Physician /Medical

Reg.	No.	4	UU	Ö		J	Ö	1	3
of Death	D		V		3.	Tim	e of	Dea	th
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Funeral Director

show Department of Health and Mental Hygiene. Important; if item 23a or 28a-f shov any injury or other traumatic event, the Medical Extending to other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other traumatic event, the Medical Extending to any injury or other extending to any injury oreason or other extending to any injury or other extending to any

Maryland 21215-0036

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P.O. Box 68760,

Division of Vital Records,

Pages 1

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Physician /Medical Examiner

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I Director: After this codin by the funeral dire

Funeral ð Completed Be Examiner Physician/Medical þ Completed Be Certification: To Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date o FREEMAN LARENCE 11,21AM 2008 10 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death GOOD SAMARITAN BALTIMORF HUSPITAL. Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 🔀 M 2 🗆 F Yrs. 83 12-27-24 219-10-6214 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Yes 2□No Director n/a Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 115 east Melrose U.S.A. 21212 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1, Yes 2 No If Xes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify:Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 grade Unkown Unkown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unkown Unkown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Klecan 110 N Calvert St Balto Md 21202

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - Cit Dept. Of Aging 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Va. Crownsville Md 10/30/08 21. Signature of Funeral Service Lie 22. Name and Address of Facility 2829 Hudson St Skarda Funeral Home Balto, Md 21224 homa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PHEUMONIA disease or condition resulting in death) Due to (or as a consequence of) SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 NNo 1∏Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registra

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Hospital 24 hours a

To the within 2.

BALTIMORE

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ABHIJEET GHATUL (MT) RES- DDO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLYD.

. Registrar's Signature

5601 LOLH RAVEN

NOV 1 2 2008

31. Date filed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed area for each. "An Director: After this certificate has been signed by the attending physician and Director: After this certificate has been signed by the attending physician and a Director: After this certificate has been signed by the attending physician and present the part of the	funeral director, page	1 Yes 2 No	28a. Da	ate of Injury		e of Injury	28c.	Injury at Wor	k? 28	d. Describe	e how injury occum o fixed object (ed collision	
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	ŏ١.	29b. Signature and title of certific	er.	/			200. LIC	OCHOC HUILIDE			1		

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner Zabiullah Ali, M.D.

State 31. Date filed (Month, Day, Year) NOV 1 2 2008

32. Registrar's Signature Contract

OCME

November 10, 2008

O.C.M.E.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 30 AM Μ. FRAZIER VIRGINIA OCT. 2008 30, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON MANOR CARE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours 1 □ M 2**X** F 251-50-0710 82 Director AUG. 30, 1926 SC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 No MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 N. CHARLES ST 21204 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 72 hours after 2 🔀 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: BLACK 2 3 X Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) 12TH FOOD SERVICE WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Is marked ROBERT A. FRAZIER ALICE HARRELL Legat 1 and 2 shoughst 1 and 2 shoughst 1 and 1. I mortant: If I tem 27 Is mark any Injury or other? 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER SIMMS/DAUGHTER 5502 CADILLAC AVE., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/06/2008 | BALTIMORE CO., MD MEADOW RIDGE 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Lice 2007-09 EASTERN AVE., BALTIMORE, MD Part I. Enter the disease, or confessions, or heart failure. List only plications that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) physician a the burial Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) 5 ☐ Pending investigation Injury within 24 hours and com...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760 P.O. or Vital Records, Division To the Hospital

Baltimore, Maryland 21215-0036

Medical

LEUNARD 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

29b. Signature and title of certifier

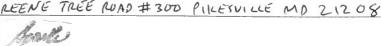
RICHARDSON M.D. 1838 GREENE



MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DSTTZZ

29d. Date signed (Month, Day, Year)

JUVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November8,2008 11:10A.[™] John G. Forney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice Care 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) Maryland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 **3** M 2 □ F 55 215-60-5203 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Profest Ext., it er must be notified at once. 1X Yes 2 □ No Baltimore City Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21224 6614 Danville Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married White 1 □Yes 2√□ No Specify. Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Cesenaro Joseph Forney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 799 Menges Mill Road Spring Grove, PA 17362 November Pauline Forney (sister) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11-13-08 Baltimore, Maryland 22. Name and Address of Facilitaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 Tarla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mach S Immediate Cause (Final - MAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached it 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Praeture -VIC 3 Probably 4 ☐ Unknown 1 ☐ Yes ≥ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No ITIS 24a. Was an performer 1 □Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year, 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 🗌 Natural 5 ☐ Pending investigation Feelout of bedat home nours after death, neral Director; Aft y filled in by the fur 1 ☐ Yes 2 No 2/2008 untram 2 Accident
3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3900 Mily View Rd/Middle Rurer 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō tt home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my salaries, death accuracy. within 24 hours a Hospital 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5642 Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Tousastorn Blud/Balto MD 21204 555 FauluerND 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year KATIE GIBSON 1:20 PM NOVEMBER 8005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOSPITAL nda 11s town DOMITHOU timore If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
North Catoline 6. Sex **Funeral** Months 1 ☐ M 2 🖫 F Days 76 Yrs. (ausling Director 44-44-629 Jan Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 N Y 2 2 No Kandallstown Director Balti more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 1SA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ ac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Disablea 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be :va SYOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) brother Balto MD 21133 pman Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial /2 Scremation 3 ☐Removal from State 13/08 Baltimore 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility We 4600 MD 2120 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BNEUMONI AS **Physician** PITLA TION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duz to (or de a consequence of, Examiner certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ίος in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? (es 2 % No this certificate 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 임 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Funeral Director: After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide To the Hospital hours Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352

Registrar DHMH 17 Rev 1/2001

State

Shot GLD COURT MAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. egistrar's Signature

HOSFITAL

2008

NOTHWEST

31. Date filed (Month, Day, Year)

NOV 12

NOVEMBER

MB

21133

TODOR

RANDALISTOWN

2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6RIMES HERBERT 07 11 OS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 € M 2 🗆 F 59 Washington, DC 01/23/1949 Director 230-70-5781 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1√2 Yes 2 No Funeral Director Washington, DC DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2302 Irving St. SE 20020 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc illed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√☐No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) سنالالله مدر مراهاته من عند عرب الماهاته من عرب م م 127 is marked other than "ت ۳ traumatic event" College (1-4or 5+) Elementary/Secondary (0-12) Television Production 3vrs 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Herbert S. Grimes Daisy Dud1ey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2302 Irving St. SE, Washington, DC Donna Grimes/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 11/14/2008 Cedar Hill Cemetery 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service License 20011 716 Kennedy St. NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MILURE immediate Cause (Final disease or condition resulting in death) HEART (MKLtinn ONGESTIVE Physician /Medical Due to (or as a consequence of): LUY NOWN Examiner MELLITUS DIABETES Securitially list coordinate fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): INSUFFICIENCY UNKNOWN that the death certificate be executed KENAL physician and s the burial-trans Due to (or as a consequence of) UHENOWN Box 68760, HYPERTENSION Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □No P.O. 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, REPTICEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been sig page 2 should b Completed ABSCESS AXILLARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vas 2 No 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Certifier D0063978 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENBEUT, MD STE 1051 DRIVEI CONTER GREEN WAY 5 25 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day GRAVES 10:36 AM **Physician** DONNA NOVEMBER 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖫 F Maryland 49 216-80-5808 26,1959 Director Usual Residence of Decedent I and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. The street of the 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State er than "natural", or items 23a or 28a-f show the Middeal Exeminar must be notified at 1 ☐ Yes 2 No Dundalk Directo Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21222 Apt. F 7907 Trappe Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. þ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Wilma Allen Hilson Pindell, Jr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ped Tion, PA 17356 19a. Informant's Name/Relationship (Type. Print) 245 Country Ridge Drive Red Lion, PA Franklin K. Graves (Son) item 27 other to Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 to permit. Page Department o Important: If any Injury or once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Holly Hill Mem. Gdns. 11/8/2008 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service License 100 × 70 Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTIC SHOCK Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): c 6 hrs INTRAVASCULAR COAGULATION Examiner DISSEMINATED Se que nistly list no cilic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine < 24 hrs law requires that the death certificate be executed BACTEREMIA GRAM NEGATIVE the burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 Mano signed by the a Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t , page 2 s performed' certificate 1 ☐Yes 2 KNo 1 XYes 2 □ No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 □ No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 5, 2008 MEDICAL RESIDENT RESODO WP. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GORDSPE, MD / JUHUS HOPKINS BAYVIEW MEDICAL CETTER / 9490 EASTERN AVE, BALTIMORE, MD EMMANUEL

State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 6 2008 ar Audrey Marie Goan 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 133 Marie Avenue Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 04/22 | Months | Days | Hours | Min. | 04/19/19/29 38 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Months 212-36-6341 70 Director New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be redfled at Director Anne Arundel Glen Burnie 1 ☐ Yes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Marie Avenue 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates \$ 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph LeBeau Lillian Milner injury or other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a important: if Item 27 is any injury or other trau once. Karen Cordle/Daughter 133 Marie Avenue, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Ardent Cremation Services 11/11/2008 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services, LLC 21. Signature of Funeral Service Licensee 0 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Subman 20 mouth. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760-Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Completed 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performe Yes 2 rector, page 2 2□No 1 □Yes 1 ☐ Yes this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.
I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number D39505 -M.D

State Registrar

31. Date filed (Month, Day, Year) NOV 12 2008

udhish Markan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

305

Hospital Dr, Glen Survier MD-21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marylahop Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7 Pay **Physician** NOV. 2008 10:10A M Thomas Patrick Gay, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2806 Taylor Avenue Parkville 8. Date of Birth (Month, Day, March 16, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Funeral Days Min. 74 219-30-0001 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f sho 1 ☐ Yes 2 No Completed by Funeral Director Baltimore Parkville MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2806 Taylor Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Police Department 12 If item 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Matthew Cay, Sr. Katherine Mary Kavanaugh ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Patricia Gay - Spouse 2806 Taylor Avenue, Parkville, Maryland 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ott cemetery, crematory or other place)
Dulaney Valley 1 □ Burial 2 □ Cremation 3 □ Removal from State Mamorial Gambre
22. Name and Address of Facility 4 ☐Donation 5 ☐ Other (Specify) Nov. 10, 2008 Timonium, Maryland 21. Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road, Parkville, Maryland 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the yeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NINUTE /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be exer Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1∐Yes 2∐No 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 2 🗌 No 3 ☐ Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performe 2 🗆 No 1 ☐ Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{ Nursing Home} \) 1 Yes 2700 Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi NOVEMBER 7, 2008

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of payon who

32 Registrar's Signature

Day, Year) 32 Hegistrar's Signature

OSLER De # 308 TOWSON, MD. 21204

Amend #1, perMD g885 11/12/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Grace Irene Turnipseed Goode 2. Date of Death . Decedent's Name (First, Middle, Last) ... November 6,2008 DIOOCA 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death tal Paltimore mayland General (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 12-26-1938 9. Birthplace (State or Foreign 5. Social Security Number Hours Min 1 □ M 2 🛛 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Ves 2 No Himore MD10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DONOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s Name (First, Middle, Maiden Surnar ather's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Tyr. Apt.8 ter) 900 Bathmore MD 21218

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11.10.08 21. Signature of Funeral Service Licensee 5151 Ho. Nati 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hely failure. List only one cause on each line. Approximate Interval Between Onset and Death deno Caremona in Liver Immediate Cause (Final disease or condition resulting in death) Petastatic Due to (or as a consequence of) Ratory tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ence of) ic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Vear Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Funeral Director 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, I'm Medical Exantine roust be notified at Director Funeral Saltimore, Maryland 21215-0036 þ Completed Be 1 and 2 s Health a Pages 1 Physician /Medical Examiner Examiner and burial-tran be exect Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic Division of Vital Records, P.O. \$ Be Completed Medical Certification: To completely filled in by the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier A. Harras 11/6/08 30. Name and address/of person wire completed cause of death (Item 23a) (Type, Print) m.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MARKE

Registrar

Physician

Examiner

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Bernard Anthony Garrity November 10 2008 2030 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Greater Baltimore Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 1**⊠** M 2□ F Months Days Hours Min. 219-07-4290 87 February 27, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2X No MD Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 613 Allegheny Avenue 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 1 942 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Dept. of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella McNallv Bernard Anthony Garrity, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Garrity / Wife 613 Allegheny Ave., Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 11-14-2008 Dulaney Valley Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final mocardial munch disease or condition resulting in death) es a consequence of): costeroly. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify). 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? իկ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal 2 No 3 Probably 4 Unknown Menns 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐ No 1 □ Yes Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria Division of Vital Records, P.O. Box 68760 signed by the a certificate has birector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

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Registrar

29b. Signature and title of certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Nov II, 2008

Saltimore Ma 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA

6701

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Marion 11:25 AM NOVEMBER 3008 /Medical 4a. Facility Name_(If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Washington, D. C 78 Yrs. Min. 577-40-9508 0/08/1930 Director Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, it in It belief Examinal must be notified at 1 Yes 2 No Director Mardand 10e. S reet and Number 10f. Zip Code 10g. Citizen of What Country? 0/ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married land 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bocher Baltimore, Mary 19a. Informant's Name/Belationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Re ute Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 Is any Injury or other traionce. Sharon Keden 20a. Method of Disposition 20c. Location 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): 5 DAYS CHRONIC LEUCOCYTIC LEUKEMIA Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed PNEUMONIA for use as the burial-transit LTILOBAR Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by LIERTON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has I ral director, page 2 s 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 1 No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD MAMEDOV 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SIMMARITHAN HOSPITAL DR. MAMEDON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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Jerry Green		State of Maryland / Departmer	it of Health and Mental Hyglene e o <i>f Death</i>	2000 0571
		Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 2008 35/4
Physicia Medical Examir		Jerry Green	2. Date of Month	Day Year
Medical Examin		4a. Facility Name (if not institution, give sfreet and number)	4b. City, Town, or Location of Death	mber 9, 2008 1207 hrs
'		3808 North Rodgers Avenue	Baltimore	* 1/A
				e of Birth(MM/DD/YYYY) 9. Birthplace (State or
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Director		214-70-9247 1 m 2 = 52	Yrs. Dec	C-22, 1953 Country) Mayland
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w any		10a. State 10b. County 10c. City, Town or	Baltimore	10d. Inside-City Limits
land f sho	5	veryland NM		
Mary 28a-	Director	3808 N. Rogers Ave.	10f. Zip Code	10g. Citizen of What Country?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygene. 27 is marked other than "natural", or items 23a or 28a-f show martie event, the Medical Examiner must be notified at once.		3808 M. Regers Ave.	21201	USA
ms 2.	Funeral		 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 	
deat or ite	ا ج	1 Never Married 2 Married Armed Forces?	res, specify cubair, Mexican, Fuerto Rican, et	Pl/
after al", o	Į,	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: Black
ours	호[cedent's Usual Occupation (Give kind of work done ring most of working life. DO NOT use retired)	16b. Kind of Business/Industry
72 h	뺼	Elementary/Secondary (0-12) College (1-4 or 5+)	Disabled	N/A
O3	Completed	مل	PISKO	177
5-0 led v Hygi		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Mi	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umnatic event, the Medica	å	Jomes Green		divis
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	P			te Number, City or Town, State Zip Code)
ME d 2 sl lth ar n 27 aums	Į	Jason Green - brother 38	OF M. Rogers Ave.	Bottimore, Maryand
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			Disposition (Name of temetery, Date or other place)	20c. Location / City or Town, State
MO Pages ent o		4 Donation 5 Other, Specify:	Tion Cemetery 11/13/0	I Candsdowne Maryland
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr	ı	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Funeral Home EA 621229
E F P F E		Herry taken	3512 Frederick Ave	. Raftimpre Mandard
Physician		23a. Part I. Enter the disease of complications that caused the death. Do not efailure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirate	
/Medical		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular	Disease	Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):		
		Sequentially list conditions, b		
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
	ami	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
d d ansit		d.		
executed ian and ial - transit	ical	UNPENDED AMENDED		
50, te be nysici		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box 68760, e death certificate be the attending physic ed for use as the bur		3b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	Month Day Year
× 6 th cer tendi	ici Cis	4 Pregnant at time of death 5	Other (Specify)	
Bo e dear the ar	ş	1 Yes 2 No 9 Unknown g Unknown		
d by		Part II. Other significant conditions contributing to death but not resulting in		. Did tobacco use contribute to the cause of death?
signe	d b	Diabetes; Chronic Alcohol Abuse; Asthma		Yes 2 No 3 Probably 4 V Unknown
requirements	Completed		24a	. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
e law	튑		4.50	performed? death?
ifficat		25. Was case referred to medical	26.Place of Death (Check only one)	Yes 2 No 1 Yes 2 No
Division of Vital Records, P.O. in or Attending Physician: The law requires that the rape after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Be	examiner? Hospital: 4 Innation 2 EB/Outs	atient 3 DOA Other Nursing Home	5 Residence 6 ✔ Other: Scene
Phy Phy eral d	의	Tes 2 No		scribe how injury occurred
on of or of	Certification:	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	,
Division Septial or Attend hours after death. murral Director:	cat	2 Accident Investigation		ation (Street and Number or Rural Route Number, City
Divi	\E	3 Suicide 6 Could not be determined (Specify)		own, State)
Dospita hour nera y fill		4 Homicide	<u> </u>	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ica	(Check only one) 2 Wedical Examiner: On the bast of my knowledge, death one)		
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	-	255. Signature and title of certifier		
		Wh U	O.C.M.E.	November 10, 2008
2		30. Name and address of person who completed cause of death (Item 23a)	D01	
ン		The state of the s	Penn Street, Baltimore, MD 21201	
Sta	ate	31. Date filed (Many) Day Teal 2008 32 Registrar's Signature	poul	
Regist	Ci)	P		

			For State	State of Man				nd Mental Hy	giene	00 3571.5					
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of De	Reg. No. U	3. Time of Death					
	Physici	an	Katherne 1	y late	tung			Novem	, Day	7 Year 245 AM					
	/Medic Examir		4a. Facility Name (If not institution, give s		lung	4b. City, Town, o	r Location of			ity of Death					
	LXamii	CI	St Blizabe	ths		Baltimo	ore		N.	I/A					
	Funeral		5. Social Security Number 6. Sex	7. Age (I	n yrs. last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da		Birthplace (State or Foreign Country)					
	Director		340-03-4928	^{M 2} ∑ F 94	Yrs.			10/14/	1914	Illinois					
	and and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits					
	Mary f sho	to	MD Baltim	ore	P	altimore				1 ☐ Yes 2X No					
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Country?					
	h with		4208 Barrington Ro	oad			21229		Unit	United States					
	ems ems	Funerai	11. Marital Status	2. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Orig an, Mexican,	gin? (Specify Yes or No Puerto Rican, etc.))- 14. R	ace - American Indian, lack, White, etc.					
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it is man 27 is marked other then "neturel", or items 23e or 28e-f show or other treumatic event, the Marical Examiner matter notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes ¾ ☐ No	Specify:		Spec						
21215-0036			15. Decedent's Educ	Year or Dates:	16a Decer	dent's Usual Occup	nation		16h Kind of	Business/Industry					
15	in 72	piet	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most	of working	100. (1110 0)	525m354m3dony					
212	e filed within al Hygiene. I other then " vent, Ine Me	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Home	maker			Ow	n Home					
	be filed ntal Hygi od other event, t	Be	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, Middle	, Maiden Suma	ame)					
yla	should the should the should the should the should be sh	ြ	Michael McGrath				Cat	herine Reid	dyy						
Maryland	2 short and reum	1	19a. Informant's Name/Relationship (Typ					r or Rural Route Numb							
	1 and 2 Health tem 27		Patty Graves (Daug		110 1 20b. Place of Dispo	South Mor	erick	Avenue, C	atonsvi	11e, MD 21228 - City or Town, State					
nor	Pages nent of int: If it		1 ☐ Burial 2 【ACremation 3 ☐ Re		cemetery, crer	natory or other place of Cremato	CO)			ore, Maryland					
Baltimore,			' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	90		2. Name and Addre									
Ba	permit. Deportr Importe any inju		1 Kingh C	Link				nubbaru r		Home, Inc.					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between												
	Pnysician	9	Immediate Cause (Final disease or condition	Severe	anti	cstel	nosis			Onset and Death V-CW-S					
	/Medical		resulting in death)	Due to (or as a c	onsequence of);		1	9		y cwrs					
	Examiner		Sequentially list conditions.	Chron Due to (or as a c		ial til	orill	ation		years					
	S: X :	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1/ 0 4 1										
	and and Il-tran	хап	that initiated events resulting in death) Last		Years										
8760,	death certificate be executed e attending physician and K of for use as the burial-transit			Due to or hac											
687	tificate ng phys as the	Physician/Medical	0.												
Вох	eath certif attending tor use as	M/ul	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of p		Tetenia era anaese			23d. E	Date of delivery					
	death	sicia	in the past 12 months? 1 □ Yes 2 WNo	4☐Pregnant at tim		Ectopic pregnancy Other (specify)	<i>'</i>		٨	Month Day Year					
P.0.	that the de ed by the a detached t	Phys	9 Unknown						_						
	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions conditions conditions	tributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	10	antribute to the cause of death? 3 Probably 4 Unknown					
orc	requi	eted		3 //1					/V_						
Vital Records,	e la has	Completed	14x her libiden	110	2			24a. Was		b. Were autopsy findings available prior to completion of cause of death?					
al			Congestive h	eart t	ailure			1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No					
₹		o Be	25. Was case eferred to medical examiner 1 Tes 2 No	ospital:	2 ER/Outpatien	. ac pos Oth	or W	of Death (Check only or rsing Home 5 - Resi		thor (Conside)					
o	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe							
ion	Attending For death. Sector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ea <i>r)</i> Injury		Yes 2 □ N	No							
Division	or Attencater death Director:	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (nber or Rural Route Number,					
	itel o rrs aft ral Di lled in	O	1/			-1.59-5-59950									
	Hosp 4 hou Fune tely til	edical	(Check only 2 Medical Examin	er: On the basis of ex	amination and/or in	n occurred at the tir vestigation, in my o	me, date and pinion, deatl	d place, and due to the h occurred at the time,	cause(s) and r date and place	manner as stated. e, and due to the cause(s)					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	Med	29b. Signature and title of certifier	and manner stated	3.	29c. Licens	e number		29d. Date sign	ned (Month, Day, Year)					
)	F > F 8			my.	7 120			11							
•	/		30. Name and address of person who cor	mplet of deat	h (Item 23a) (Type.	Print)	3 2 1		vovem	W47 0 / , 0 = 0					
	b		1.1 1.1/1 22	20 Bensi	A	nue, B	alti	more M	laru (a	her 07, 2008 and 21227					
	Sta		31. Date filed (Nonth, Day, Year)	32 Registrar's		-			7						
	Registi	ar	**************************************	U ASSE MARIA	RI RO	ALL S									

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 3574										
Physic			1. Decedent's Name (First, Middle, I	.ast)				2. Date of Dea	ath	3. Time of Death			
	Physici /Medi		Andrew H	ardon				NOV.	9 Day 2008 ear	1845 M			
	Exami	ner	4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	1	4c. County of Death				
spec "		,	7838 Daniel 5. Social Security Number 6.			Park	ville		Balt	imore			
	Funeral Director		215-92-9228	Sex 7. Age 1	(In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)				
			Usual Residence of Decedent					June 1	0,1963	MD			
Maryland 21215-0036			10a. State 10b. County	ocation 10d. Insid									
	he Ma					kville		1 □ Yes 2X No					
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Sith and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Predictal Executing must be notified at	Ö	7838 Daniels Avenue			10f. Zip Code	234	1	10g. Citizen of What Cour	itry?			
		Funeral	11. Marital Status	12. Was Decedent Eve	erin IIS 12 1				USA				
			Armed Forces? 1 ★ Never Married 2		'	Was Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.				
		d by				1∐Yes 2∏ x No	Specify:		Specify: White				
	"natu	To Be Completed	15. Decedent's 8 (Specify only highest g	Education rade completed)	16a. Deced	dent's Usual Occupa	ation uring most of work	rina	16b. Kind of Business/Ind	dustry			
7	within ene.		Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done di DO NOT use retired) ftsman	and the state of t	in g	Construct	rion			
о О	filed Hygi Sther ent, I		12th 17. Father's Name (First, Middle, Las	it)	DI a.		18 Mother's Nam	e (First Middle I	Maiden Surname)				
lan	2 should be and Mental is marked o aumatic eve		Stephen Har	don				en Susk					
ary			19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street a			r, City or Town, State, Zip	Cade)			
	and 2 lealth a m 27 is her trat		MArk Shield	/brother-i					utherville				
ore	Jes 1 If iter or oth		20a. Method of Disposition 1 Description 20 Description 20 Description 20 Description 30 Description	Damaual from State	20b. Place of Dispos	sition (Name of natory or other place	,)	Date	20c. Location - City or To				
Ē	ment of tant: If ite		4 Donation 5 ☐ Other (Spec	ify)	Gardens	of Fait	h 11/	12/08	Rossville	e MD			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Full rai Service Dice	onsee /	22	. Name and Address	of Facility 300) MAce	Ave. Balti	more MD			
			230 Part 1 Enter the diseases of an	ly corne	19 /	Connell	v Funer	al Hom	e of Essex	21221			
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	ope cause on each line.	e eath. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
	Medical		disease or condition resulting in death)	a Asphy	XIQ D	Mar	19140	l		Chact and Death			
	Examiner			Due to for as a	onsequence or):		, ,)					
	D +	ner	Sequentially list conditions, it may be cause. Enter Underlying Cause (Disease or injury that initiated events	one-quenes of):									
	ecute ind transi	Examiner	Cause (Disease or injury that initiated events										
,60,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):								
ò	physi the t	dical		d									
ς X	certificate iding physise as the	/Me	IF FEMALE:	23c. If yes, outcome of p	oregnanov.								
POX	atter for u	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year			
5	by the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	lo or death 5 🖸	Other (specify)				.,			
Z, T	s ma gned l e dett		Part II. Other significant conditions	contributing to death but n	ot resulting in the un	derlying cause given	in Part I.	23e. Did tob	acco use contribute to the	e cause of death?			
ecords	equire en si	ed							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
ပ် မြ	as be	Completed						24a. Was an		sy findings available			
ב =	rne sate h page	6						autopsy perform		pletion of cause of			
VILAI	cran Sertific ector,	Be (25. Was case referred to medical examiner?			2	26. Place of Death			2 (3(10)			
5	this aldin	P.	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
	After funer	E.	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 1 Accident Investigation (Notember 9, 208 \$4.5 M 1 Yes 2 No \$5.4 C \$4.5 M \$5.4 C \$5.4										
VISIOII		Medical Certification: To	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		M 1 Yes 2 No Suicide by Hangin factory, office 28f. Location (Street and Number or Rural noute)								
5			4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)			28f. Location (City or To			Street and Number or Rural route unber with State 8 Daniels Ave				
penis			29a. Certifier 1 CertifyIng Pt	vsician: To the best of m	v knowledge death	occurred at the time	date and place	and due to the co	4 WG 5	12.34 ated.			
H			one) and manner stated.										
Ē		2	29b. Signature and title of certifier	1 111	1	29c. License r	number		d. Date signed (Month, D				
	7	4	30. Name and address of person who completed gause of death (Rem 23a) (Type, Print)							2008			
7	7 '		30. Name and address of person who	completed cause of death	(Rem 23a) (Type, P	imble H	11 0	11.00 .	-11- MI	71202			
1	State	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature 8	IMDIG H	ill Ci. L	UTNUIO	1.16 1.19	21043			
	Registra	~	NOV 1 2	2008 1850	1 15 A	MASK!			-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 1,2008 **Physician** Dorothy Holbrook 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 20 Transverse Avenue Middle River If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 10,1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 217-24-7134 78 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarance must be notified at once. rector 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 這 20 Transverse Avenue 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Yes 21 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No Specify. ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 8 years Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Hughes Emma Hughes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Holbrook Daughter 6938 German Hill Road, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 14, 2008 4 ☐ Donation 5 ☐ Other (Specify) ure of Fureral Service Licen. onnelly funeral Home Of Dundalk 7110 Sollers Point rd. 21222 MASSU 23a. Part 1. Enter the disease shock, or heart failure. I complications that caused the death Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Fronth **Physician** letastas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dise to for as a consequence on cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Physician/Medical as IF FEMALE for use yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months: Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown signed to Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 WNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, certificate e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p the the To the within 7

certificate be executed

Box 68760,

P.0.

and

attending physician

has

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

28a-f show

State Registrar

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Medi

29a. Certifie

29b. Signatu

(Check one)

31. Date filed (Month, Day, Year) 1 2008 NOV

and title of certifie

32. Registrat's Signature

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type: Print)

100 Min (M.D.) 7114 Philadelphia Road #208 Soldinore MD21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician HERDLD Month Day HELEN, R, Year 16:47PM 10, 2008 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 087-20-6980 1923 New York Usual Residence of Decedent 10b. County show 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, Ite Modical Examinar must ke notified at Director Maryland NA Baltimore 1 Y Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 110 North Kenwood Avenue Funeral 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ifiled within 72 hours after of Hygiene.

Other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√ No ð Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Sales Hutzlers Department Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Otto Wagner Freda Wasmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward Herold (Son)
20a. Method of Disposition 14023 Heatherstone Dr. Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 □xBurial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 4 Donation 5 Dother (Specify) 14, 2008 East Point, Maryland 21. Signature of Funeral Service Center 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. 23a. Part 1. Enter the dislause, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Caused (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) HOUR /Medical Due to (or as a consequence of): Examiner YLMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): STROKE Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month signed by the a 5 ☐ Other (specify) Records, P.O. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably *☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate ha Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this Certification: To 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 14 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-DOD NOVEMBER 10, 2008

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State Registrar 31. Date filed (Month, Day, Year) 32. Begist

CHRISTINE MATIVO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 4940 EASTERN AVENUE, BALTIMORE, MD 32. Degistrar's Signature

A COLUMN A

DHMH 17 Rev 1/2001

Amend #5, per FH G886 12/5/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 9: 24pm Physician Leon HENR 08 11 WAVEZly /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4h City Town or Location of Death Examiner BALTIMORE NIA VA Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠**M 2□F **Director** 82 11-9-1926 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or rother traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director MD BALTIMORE TURNER STATION 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 404 MAPLE LANE 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1950-52 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BETHLEHEM STEEL PIPE FITTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NAFROTH PORTER ဂ္ဂ COLEMAN HENRY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s I Health a BALTIMORE, MD 21222 404 MAPLE LANE EARNESTINE HENRY/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-14-08 OWINGS MILLS, MD GARRISON FOREST CEM. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part P Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-transil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a P.0. 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1□ Yes 2 **N**0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ spital or Attending Phys hours after death. Ineral Director: After this y filled in by the funeral di 27. Manner of Death 1 W Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

X State

Shere 31. Date filed (Month, Day, Year)

V OI Noreen 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Bachmore

			For State Registrar	State of Ma	aryland			of Health of Death			giene 2 Reg. No.	2008	357	5
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date						2. Date of De	of Death 3. Time of Death				
-	/Medic Examin		4a. Facility Name (If not institution, gi			2 1	4b. City, To	vn, or Location			4c. Co	ounty of Dear	1 2	
	Funeral Director		5. Social Security Number 6. S		le (In yrs. la:	st birthday) Yrs.	If Under 1 Months E		er 24 Hrs.	8. Date of Bir Month, Di	th	9. Bir	chplace (State or Fo	
	D		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Li	mits
50 after death with the Maryland	e Mary 8a-fsh	ctor	MD Anne Ar	undel	Se	vern							1 □Yes 2] No
	with the	l Dir	10e. Street and Number 8075 Quarterfiel	d Road			10f. Zip Co	ode L 144			10g. Citizer	of What Co	-	
	be filed within 72 hours after death with the Marylan Hygiene. Hydiene. At Hygiene, do other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at	/ Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 2 Yes 2 1			Vas Deceden Yes, specify	7		ecify Yes or No Rican, etc.)		Race - Ame Black, White pecify: W		
9500-c	72 hours after "natural", or ite	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						ing	16b. Kind of Business/Industry				
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yland A	ould be filed v I Mental Hygid Iarked other Iatic event, II	To Be C	17. Father's Name (First, Middle, Las Andrew Handsch	_				1	her's Nam I ry	e (First, Middle Kuhn	, Maiden Su	rname)		
<u>a</u>	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship Mr. Mark Handsch				-	treet and Num		al Route Numb		own, State,	Zip Code) 21144	
υ,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ABurial 2 Cremation 3 Department of Company 2 De	Removal from State	cer	metery, crem	sition (Name latory or othe	of r place) norial		Date 4-2008		ion - City or	Town, State	
Бант	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice		714	22	. Name and	,	ilitySing		Funera	1 & C	remation 3	Srv
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. TriEumonic Due to (or as a consequence of): MYD CARRAGOM The PARTICON											
	ured d ansit	Examiner	Sequentially list conditions							-				
6/00,	icate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as	a conseque	ence of):							-	
		Medic	IF FEMALE:	u										
O. BOX	Ine law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	onths?						23d. Date of delivery Month Day Year				
ds, r.	urres tnat signed by Id be detad	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							d tobacco use contribute to the cause of death?				
Hecords	The hospital of Attending Prhysician: The law requires that the of whithin 24 bours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed	au pe								prior to completion of cause of death?			
VII al	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?						ce of Dea	1 □Yes th (Check only		I Li fes	2 🗆 140	
5	r this c	ဥ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien 28b. Time of		Other: 4 🗆 I	Nursing H	ome 5 🗆 Res			ecify)	
VISION OF	trenaing leath. tor: Afte the fune	Certification:	1	n		Injury	М	Work? 1 ☐ Yes 2 [□No	201 1				
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ŀ	n 24 ho n 24 ho ne Fune oletely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	withi To th	Ň						29d. Date signed (Month, Day, Year) November 10 2-008						
•	5	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Surfryo 301 hospital drive Gler Burne N							. 607 61	rember 10 2005				
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	Registra		NOV 1 2	2008	10. 1	4 1	Bake &							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] § Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7. 20 PM AMES HARREI No 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OL (27) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last bjrthday) **Funeral** 1. M 2□ F 212-42-574 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 21133 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No r than "natural", o ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) of Health and Mental Hygiene.
Item 27 is marked other than other traumatic event, I'm M. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harrel 19a. Informant's Name/Relationship (Type. Print) nt of Health a t: If item 27 is y or other tra Sheila 9403 wite rdallstorn, MD 2133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1⊌Burial 2 ☐ Cremation Department of Important: If any Injury or once. Bartimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Greene funeral sur 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death day Immediate Cause (Final SEPSIS **Physician** MULTIORUAN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number NOV, 05, 2008 LES ODI M.C-J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HANOVER ST BALTIMORE MO S 21225 SUBHACH BUSE . Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month , Year Nov CATHERINE ROSE HARE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 20 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 😿 F MARYLAND 215-40-0753 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'v. Madical Examiner rust by notified at 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD HARFORD WHITE HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3023 BRADENBAUGH RD 21161 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ Specify: WHITE 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEO J. McCARTHY CATHERINE STREB ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a HARRY HARE (SON) 3023 BRADENBAUGH RD WHITE HALL, MD. 21161. item 27 other to 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Į, permit. Pages Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State SATERS 11/11/2008 LUTHERVILLE, MD. à ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SONS CO. HENRY W. **JENKINS** & 16924 YORK RD MONKTON, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 11836 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ed by the a detached f 9 Unknow signed by the signed of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 □ No 3 ☐ Probably 4 Unknown Completed arterioscierot Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 🗆 No Was case examiner? Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral e Hospital or Attending P 24 hours after death. e Funeral Director: After t 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 □ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death assured with the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

555 gistrar's Signature 32.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 5 State of Maryland / Department of Health and Mental Hygiene Per fh, g886, 12/15/08dhb Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** OPKINS 11:40 AM amue 2008 Vovember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facilify Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 21°5 510 1491 7. Age (In yrs. last birthday) Days 10/18/1913 **Funeral** 1 X M 2 □ F 95 MARYLAND Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21210 USA 45 WARRENTON RD. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 X Yes 2 ☐ No If Yes, Give Year or Dates: ✓ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) INVESTMENT BANKER BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERTA SMITH SAMUEL H. HOPKINS ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 45 WARRENTON RD. BALTO., MD. 21210. ANNE D. HOPKINS(WIFE) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition Department of important: If It any injury or o once. 1 Burial 2 Cremation 3 Removal from State GREEN MOUNT CREMATORY 11/7/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HENRY W. JENKINS & SONS OF THE ans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause o each line. Annroximate Interval Between Onset and Death Immediate Cause (Final **Physician** 50 disease or condition na /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical attending phy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed I lirector, page 2 should be de þ Division of Vital Records, 2. No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Hospital: 1 Xinpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Al 2 Accident filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

November 5,2008

600 North Wolfe St, Baltimore, MD, 21287

08-08399 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 35755

			- For State Registrar	Ce	rtificate of	Death		Re	eg. No.	,00 0010		
	Physicia I Examii	ın/	1. Decedent's Name (First, Middle,Last)					2. Date of Death Month Day November 8, 2008 3. Time of Death 1917 hrs				
			4a. Facility Name (if not institution, give s Eastern Boulevard at Volz A		4	b. City, Town, or Middle Rive		eath	4c. County of D Baltimore (
F	uneral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24	Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9	. Birthplace (State or Foreign		
D	irector			2 F 40	Yrs.	Months Day	s Hours	Min. 12-29	-1968	Maryland		
	any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limits		
	ž	اة	Md. Baltimo	ore Mi	ddle R	iver		1 Yes 2 X No				
	Maryl:	ect	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Country?			
	h the l	₫	301 Shagbark I	Road		2122			U.S.A.			
•	filed within 72 hours after death with the Maryland I Hygiene. cd other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	Funeral Director	1 X Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 Yes 2x No	n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	White, e	merican Indian, Black, tc. White				
•	s afte	2	3 Widowed 4 Divorced II 15. Decedent's Education (Specify only	Yes, Give Year r Dates:		Yes 2X No		Lof work done	Specify: 16b. Kind of Busine			
	"natu	Ę	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life			TOD. MING OF BUSINE	ess/industry		
36	led within 72 hours after Tygiene. other than "natural", the Medical Examiner	Completed	9th		Self	-Emplo	yed		Self-	Employed		
21215-0036	Hygies other the M		17. Father's Name (First, Middle, Last)		1			ame (First, Middle, I				
121	l be fi ental l arked vent,	Be	John Walter Ha					n Homshe				
MD 2	ages I and 2 should be filed within to f Health and Mental Hygiene. It: If item 27 is marked other the other traumatic event, the Med	-	19a. Informant's Name/Relationship {Typ Nancy Louise Di	aper/siste	er 317	Kormit	Drive	e Red Li		17356		
ē,	s I and of Healt If item er trau		20a. Method of Disposition 1 Burial 2 XCremation 3	Romoval from State	Place of Dispos crematory or oth	ner place)	- 1	Date	20c. Location - Ci			
<u>E</u>	Page nent o ant: or oth		4 Donation 5 Other Specify:	Ba						ore,Maryland		
Baltimore,	permit. Pages I Department of I Important: If i injury or other	. [21. Signature of Funeral Service License	e						rai Home,PA e, Md.21222		
L-CH	ysician		23a. Part I. Enter the isease, or complic							Approximate Interval		
//	Medical		failure. List only one cause on each Immediate Cause (Final disease a. C	i line. hest Injuries						Between Onset and Death		
×	aminer		or condition resulting in death) Due to (or as a consequence of):									
		<u>-</u>	Sequentially list conditions, if any, leading to immediate b	e to (or as a consequence	of):	-	_					
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	icate be executed physician and the burial - transit		events resulting in death) Last d.	ue to (or as a consequence	of):	_						
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.89	- CI) (A	ian	past 12 months?	1 Live birth 4 Pregnant at time of o	looth	tal death 3 her (Specify)	Ectopic pre	egnancy	Month	Day Year		
Box 68	e death the atte ed for 1	Physicia	1 Yes 2 No 9 Unknown	9 Unknown	3 00	ner (opecity)						
P.O.	at the d by the etache		Part II. Other significant conditions	ontributing to death but not	resulting in the u	inderlying cause	given in Part I.			te to the cause of death?		
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ords	v requir s been s should	Completed						24a. Was auto	osy prio	re autopsy findings available or to completion of cause of		
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<u>=</u>	certificate rector, page	Bec	25. Was case referred to medical examiner?			26.Plac	e of Death (Ch	neck only one)				
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Division of Vital Records,	ding Ph h. After ti funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) Nov 8, 2008	28b. Time of I 1916 hrs		ury at Work? Yes 2 ✔ No	Pedestrian	how injury occurred struck by auto	*		
sio	Attend r death ector: by the	cati	2 🗸 Accident Investigation	28e Place of Injury - At	home farm stree				Street and Number of	or Rural Route Number, City		
Divi	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	Suicide 6 Could not be determined	(Specify) Major Roa		-	zanang, oto.	or Town	State)	nue, Middle River, MD		
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as		One Continue	n: To the best of my knowle								
	To the within 2	Medical	29b. Signature and title of certifier	nd manner stated.		29c. Licen				(Month, Day, Year)		
			Ca, a o A	PRIONE			M.E.		November 9,			
	,	}	30. Name and address of person who co	mpleted cause of death (Ite	m 23a)				1			
1	8		· · · · · · · · · · · · · · · · · · ·	t Medical Examiner	111 Penn S	Street, Baltim	nore, MD 2	1201				
	St Regist	ate	31. Date filed (Month Day Year) 200	32 Registrar's Signa	ture	180 2						

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Physici /Medi		Registrar Decedent's Name (First, Middle, Last) Rodney louis Ingram			Certific	ate of	Death	2. Date of D Month	, Day	Year 10 200	3. Time of Death
Examin Funeral Director		4a. Facility Name (If not institution, give s Seasons Hospice 5. Social Security Number 6. Sex	7. Age	(In yrs. last birth 42 y		Rander 1 Year	r Location of Dea andallstow I If Under 24 Hrs Hours Min	∩ S. 8. Date of B	irth Pay, Year)	9. Bir	th tinore thplace (State or Foreign buntry) M)
	Director	Usual Residence of Decedent 10a. State 10b. County MD n/a		10c. City, Town	or Location	e					10d. Inside City Limits 1 [XYes 2 □ No
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Madical Examinat rount be notified at	by Funeral	10e. Street and Number 1608 N. Smallwood Street 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	2≘t 12. Was Decedent Ev Armed Forces? 1	ver in U.S.	13. Was De	. Zip Code 212	216 lispanic Origin? (san, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0- 14.	USA Race - Ame Black, White pecify:	erican Indian,
be filed within 72 ho tal Hygiene. d other than "natu event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Decedent's l 'Give kind of life. DO NO CONSTR	f work done o T use retired	during most of wo d) Vorker		Trista	of Business/ te Mill	·
should be file and Mental Hi s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Charles Ingram 19a. Informant's Name/Relationship (Type)	pe. Print)	19b. l	Mailing Add	ress (Street		me (First, Middle Lossie Lee Jural Route Num	2		Zip Code)
ages 1 and 2 int of Health a t: If item 27 is / or other tra		Crarles L. Ingran/Fa		20b. Place of I	Disposition (Name of or other place	Windsor M	ill, MD 21 Date 14-08	20c. Locat	tion - City or	Town, State
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flossie Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Charles L. Ingran/ Father 20a. Method of Disposition 15Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Number or Rural Route Number, City or Town, State, Zip Co. Charles L. Ingran/Father 22. Name and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Number or Rural Route Number, City or Town, State, Zip Co. Charles L. Ingran/Father 22. Name and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Number or Rural Route Number, City or Town, State, Zip Co. Charles L. Ingran/Father 22. Name and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Number or Rural Route Number, City or Town, State, Zip Co. Charles L. Ingran/Father 22. Name and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Number or Rural Route Number, City or Town, State, Zip Co. Charles L. Ingran/Father 22. Name and Address of Facility Wylie Funeral Home P.A. of Balley and State (Street and Number or Rural Route Number, City or Town, S											
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eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of							
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an: The law rifficate has t tor, page 2 s	e Completed	25. Was case referred to medical					26. Place of De		opsy ormed? 2 ANo	24b. Were au prior to death? 1 □ Yes	ntopsy findings available completion of cause of
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ospital or Att hours after d ineral Direct ly filled in by 1		3 ☐ Suicide 4 ☐ Could not be determined 29a. Certifier 1 ☐ Certifying Phys	28e. Place of Injury building, etc.	my knowledge,	death occur	red at the tir	me, date and plac	City or To	wn, State) e cause(s) ar	nd manner as	s stated.
To the He within 24 To the Fu	Medical	(Check only one) 2 Medical Examir 29b. Signature and title of certifier	and manner state	ed.							
6		30. Name and address of person who con	rco Bi	ath (Item 23a) (T	ype, Print)	35 8	mith A	venue	Balt	rmon	n, Day, Year) 11, 2008 L MD 21209
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	130	affect.					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Physician Vannie 10 2008 4c. County of Death 3:25 Am /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Bout more
If Under 24 Hrs. 8. Date of B NIA H one Homewood If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign **Funeral** 1□M 2♥F Months Days Hours 215-24-686 Usual Residence of Decedent Director 2 should be filed within 72 hours efter death with the Merylend end Mental Hygiene. 10a. Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits Baltimore 1 Nes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21 Funeral 12. Was Decedent Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race ver in U.S 11. Marital Status American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0020 Specify: \$ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Secondary (0-12) marked other than College (1-4or 5+) Provider Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) atay the LA 20c. Location - City of Town, State oren 11 19 08 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other) 5 Baltimore, + Burial 2 A Cremation 3 □ Removal from State ŏ Greenmount Cremat Crematory **Department** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fane al Service Licensee, unexed Home, 23a. Perl1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD DIQIG **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attanding Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. that initieted events resulting in death) Last Due to (or as a consequence of) After this certificete has been signed by the a funerel director, page 2 should be deteched to Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 YES 2 710 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 3□ DOA 28a. Date of Injury (Month, Dey Yeer) To the Hospital or Attanding Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title et 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23.) (Type, Print) Ruh . 0.0 0094 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 12 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5^{Day} **Physician** Nov. 2008 Terry L. Johnston 0:30A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ivy Hall Nursing Center Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 23, 1960 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 215-74-8980 48 MD **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The matt. If item 27 is marked other than "natural", or items 23a or 28a-f show mit. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If " or office I = Infiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MD Baltimore Middle River 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 122 Yawmeter Drive 21220 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Mayes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Okey Johnston Sylvia McClanahan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Pickle / Department of Health Important: If item 27 any injury or other trong once. 122 Yawmeter Drive Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 11/7/08 Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine The law requires that the death certificate be executed burial-tran and Box 68760. the attending pl for use as t IF FEMALE: f yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 20 No 1 □ Yes 2 No 1 ☐ Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 1 Ql

Registrar
DHMH 17 Rev 1/2001

State

32 Registrar's Signature

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month **GEORGE** THOMAS JOHNSON, SR. 12º10PM lovember 5.2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 X M 2 □ F Months Hours Min Director 577-12-4627 87 APRIL 13, 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits event, the Medical Exacutant rust be notified at Director 1 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? $\int \mathcal{O} \mathcal{L} \mathcal{N} \mathcal{SO} \mathcal{D}_1 = \mathcal{C} \mathcal{C} \mathcal{O} \mathcal{C}$ Baltimore, Maryland 24215-0036 Funeral 8841 EAST GROVE 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XX ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify þ Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Int: If item 27 is marked other than 10TH CHIEF OF PROTOCOL PRIVATE (IDBA) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) JOHN MONROE LILLIE JOHNSON ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Dickerson/Daughter 8841 East Grove Upper Marlboro, MD Department of Heal Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 11-13-2008 LANDOVER, MD ure of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 23a. Part Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Examiner respiran Sequentially list conditions, if any the ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the Inneral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transi Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 4 ☐ Pregnant at time of death Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed nemia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate has page 2 s 24a. Was an autopsy 1 ☐Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

٦ of Vital Records, Division

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number D65909

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

11/6/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

uck Rd., Lanham, MD 20706 6000 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 8 35760

П	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		EARL JACKSON					NOVEMBI			2030 M
	Examir	er	4a. Facility Name (If not institution, give street and n	umber)		4b. City, Town, o	r Location of Death	ו	4c. County of Death		
4 55 "			FORT WASHINGTON HOSPITA			FORT WAS					ORGE'S
	Funeral Director		5. Social Security Number 6. Sex 1 🗓 M 2 🗆 F	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	th ay, Year)	Cour	place (State or Foreign ntry)
			193-34-3743 Usual Residence of Decedent	63				NOV 12	, 1944	J PA	
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation			-	1	0d. Inside City Limits
	a-fs	cto	MD PRINCE GEORGE'S	FOR'	r Wash	INGTON					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Cour	itry?
	23a	ral	2600 BRINKLEY ROAD #510)		20744			USA		
	er deg	Funeral	Armed F		S. 13, \	Nas Decedent of F f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Ra	ace - Americ ack, White,	
36	s afte	by F	1 ☐ Never Married 2 【 Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or		1	I∐Yes 2∭XNo	Specify:		Spec	ific	
5-0036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the "Marifeal Examit at most be traffied at	pa	15. Decedent's Education	Jates:	16a Decec	dent's Usual Occup	ation		16b. Kind of I		ACK
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2121	d with giene er tha	Completed	12TH	(1-4or 5+)	MAIL	HANDLER			US POS	TAL S	ERVICE
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<u>V</u>	should be and Menta s marked umatic ev	ဂ္	EDDIE JACKSON				JOSIE M	IADDEN			
Maryland	2 sho n and is m raum		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numb	er, City or Tow	n, State, Zip	Code)
	12 # C		JOAN_ANN_JACKSON_/ WIF			RENA ROAI		UITLAND	·	0746	
Baltimore,	Pages 1 annent of Heannent of Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	State 20b. P	lace of Dispo: emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location	ı - City or To	wn, State
<u>=</u>	it. Pa rtmer rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)	HAR		EMORIAL P.	<u> </u>		LANDO'		
Ba	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Se Lio see	T D D GT		. Name and Addre					
			23a. Par 1 Enter the disease, or complications that	LD R. GF		4308 SUIT			LAND, I	MD 20)746 Approximate
		e H m	shock, or heart failure. List only one cause on	each line.			ig, such as cardiac	or respiratory a	irest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	RONARY A		DISEASE					
	Examiner		CON	or as a consequ ICFSTTVF	,	FAILURE					
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	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events								
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X R R	attend attend or us	ian/	in the past 12 months?	itcome of pregna birth 2 ☐ Fetal	death 3 [Ectopic pregnanc	y			at <i>e</i> of delive	ery Day Year
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7.	w requires that the d been signed by the should be detached	Physi	Part II. Other significant conditions contributing to o	leath but not resu	Iting in the un	iderlying cause give	en in Part I.	23e. Did to	obacco use cor	ntribute to th	e cause of death?
dS	uires n sign ld be	d by	CHRONIC KIDNEY DISEASE		J	, 3 3			∕es 2□No		ably 4 ☐ Unknown
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VItal	sician: The law s certificate has b irector, page 2 sl		25. Was case referred to medical				00.01	1 □ Yes	2 No	1 ☐ Yes	2 □ No
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~	h		30. Name and address of person who complete Cau HAWANI TEMESGEN 6104 0.	se of death (Item LD BRANC		· ·	EMPLE HII	I.S. MD	20748		
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Registrar

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2008 ALLEN С. JOHNSON, SR. NOVEMBER 8, 3:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S 2003 GAITHER STREET TEMPLE HILLS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours **Director** 578-50-3296 70 DC JAN. 2, 1938 Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment out to notifie of an once. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MDPRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 GAITHER STREET 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 2□No 1957 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 2 Specify: 3 Widowed 4 Divorced BLACK 1961 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CURRENCY CONTROLLER-VERIFIER BUREAU OF ENGRAVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NEIL K. JOHNSON EDITH E. DORSEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES M. JOHNSON / WIFE 2003 GAITHER STREET TEMPLE HILLS, MD 20748 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM 11-14-2008 SUITLAND, MD ture of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 20746 4308 SUITLAND ROAD SUITLAND, MD 23a. Parti Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** COLON CANCER disease or condition resulting in death) 18 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. ned by the a detached f □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? 1 □Yes 2 🕅 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) D64234 NOVEMBER 11, 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) NICHOLAS DEMONACO 8926 WOODYARD ROAD STE 201 20735 CLINTON, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 2 2008 Registrar

			4 60	partment of Health and Mo Certificate of Death		0000	25762
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. t	No.Z U U O	3. Time of Death
	Physici		Claire Bockler Jenna		Month I	Day Year 10 2008	
The same of the sa	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
and of			Brightview Assisted Living	Bel Air		Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd:	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign
	Director		218-26-7989 To Make 1 To M		03/09/193	80 Mar	yland
	land ow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
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	or 28g	Director	10e. Street and Number	10f. Zip Code		Citizen of What Co	ountry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examirer roust be notified at	la [300 W. Ring Factory Road	21014	U	.S.A.	
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐Yes 2 ☑ No Specify:		Specify: Wh	
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p	al Hy other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Surname)	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rectified at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	sposition (Name of rematory or other place) The state of the state of	^{120c.} 12008 Hai	Location - City or nover, Ma	
alti	mit. I partm >orta / injui		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Arde	ent Crema	tion Ser	vices. LLC
m	B T De		150/2-1	7522 Connelley Driv			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	of Liver			Onset and Death
أمر	/Medical Examiner		resulting in death) Due to (or as a consequence of):				722.
	LXdiffillei	_	Sequentially list conditions, b.				
V/	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
-L	execunand and al-train	Examiner	that initiated events c				
8760,	ficate be executed physician and s the burial-transit	dical	d				
89	rtifica ng phy as th	ledi					
Вох	th certendir	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of de	
П	e dea the at red fo	Physician/Me	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
P.O.	hat the d by letach	된	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	condedicing access when in Deat I	00a Did tahaan		the cause of death?
ds,	signe d be	d b	The state of the s	didenying dause given in Parci.		2 □ No 3 □ Pi	/
Š	v requ	etec					
æ	he lay e has ige 2	Completed			24a. Was an autopsy performed?	prior to	topsy findings available completion of cause of
ta	an; T tificat tor, pe		25. Was case referred to medical	26. Place of Death (1 □ Yes 2 ☐f		2 No Assisted
<u> </u>	lysici lis cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other	e 5 Residence	6 Other (Sne	7.52
0	ng Ph fter th neral	Ë	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury In	of 28c. Injury at 28	d. Describe how inj		City)
Ö	endin sath. or: A	äţ	2 Accident investigation	M 1 □Yes 2 □No			
Division of Vital Records,	or Att after de Direct in by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28	f. Location (Street a City or Town, Sta	and Number or Ru ite)	ıral Route Number,
_	spital ours neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath accurred at the time, date and place, or	ad due to the equa	(a) and manner a	o ototod
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	d at the time, date a	nd place, and due	to the cause(s)
	Vith Con I	ž	29b. Signature and title of certifier	29c. License number		Date signed (Month	
		14	My M	239889	N	ovensu	10,2008
	6		30. Name and address of person who completed cause of death (Item 23a) (Typ				
	Stat	e_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	n		1	
	Registra		NOV 1 2 2008 Ange &	parti			

DHMH 17 Rev 1/2001

#31 ok Par Deceree

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Year 1:51 /Medical Novemb Facility Name (If not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Memoria OSbita to altimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 6. Sex 8. Date of Birth (Month, Day, Y 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 K F Year) Months Days Hours Min 8 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Modical Examinations to other traumatic event, Its Modical Examinations. 10c. City, Town or Location 10d. Inside City Limits MD Baltinore 1 Yes 2 □ No Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. Black Completed by Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) ·B. France Iterahts Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State Kalto., Ma oudon tark 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Greene Funeral Services 22. Name and Address of Facility Vaughn Kalto, Ma. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MEUMONI week / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or as a conse mence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Day Year 5 ☐ Other (specify) the 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 TYes 2 🗌 No within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DiWisson JA 4 Day, Year) 32. Registrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Degedent's Name /First, Middle, Last) 2 Date of Death Day **Physician** Valters 6:18PM November 8 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sinai pita Baltimore Cit If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F 8 Months Days Hours Min 579-36-4601 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Forest 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use refired) than Elementary/Secondary (0-12) Cenege (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, Ihe Magnes. Olic ommunications dyrs Father's Name (First, Middle, Last) 18. Mother's Name Be lay ဂ္ and Number or Reral Route Number, Cit 🛂 Town, State, Zip Code) Informant's Name/Relationship Balto. 2911 tirest 20a. Method of Disposition Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service Lig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart refure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 □No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2☑No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death. 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Balvedore Ave

Baltimore, MD 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

2401

32. Registrar's Signature

mc Cinley

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 8, 2008 18:23 David Wickham Jones 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. June 5, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Ohio 302-32-6630 June 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland | Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane, #556 20852 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛛 No Specify 3 ☐ Widowed 4 ☒ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Internal Elementary/Secondary (0-12) College (1-4or 5+) Tax Attorney Revenue Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Wickham Jones Juliet Barker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Plain View Road, Bethesda, Maryland 20817 Elizabeth Jones Wehr / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Nov. 11, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Jurvice Lide Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one callse in each line. s a consequence): INSTION Due to (or as a consequence of). 23d. Date of delivery 3 Ectopic pregnancy Month

Physician /Medical Examiner

> and physician as the burial-t

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signed by the attending I be detached for use as

s peen s

funeral director,

After this

Jas certificate ha

Physician

/Medical

Examiner

Director

Funeral

Completed by

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine Completed by Physician/Medical Be Certification: To

Medical

Immediate Cause Final disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BRILLATION 2 No 1 ☐ Yes 24a. Was an autopsy perform 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours after death

To the Funeral Director:
completely filled in by the f To the

Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

State NOV 12 Registrar

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

4 \ Homicide

5 Pending investigation

6 ☐ Could not be

determined

2008

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 No

ame and addr Ku, SR 316, Rockwile, US 20852 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Year Month Physician 9 Chian-Li Jen November 6:49 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10278 Nolan Drive Rockville Montgomery 8. Date of Birth (Month, Day, Jan. 5, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 ☑ M 2 □ F 036-34-9792 66 1942 Director China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Mascal Examinar transfer per printed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10278 Nolan Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guang-De Jen Shu-Lian Wu ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Mosman / Daughter 10278 Nolan Drive, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Nov. 14, 2008 Bethesda, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Robert A. Fumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter tile dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failule. List only one cause on each line. Approximate Interval Between Onset and Death yrs 10 mos Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Tyes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 □Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 PN Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature ap 29c. License number D0055065 Nov. 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 Martin Edelman, M.D., 22 South Greene Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) NOV 12 32 Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

Box 68760

P.0.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Honnen Johnson November 10:30 p м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Gaithersburg Wilson Health Care Center 8. Date of Birth (Month, Day, FEB 21 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🗶 F 504-36-5871 86 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8600 Lime Kiln Court 20886 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐Yes 2 XNo <u>م</u> Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Honnen Karoline Keller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George G. Johnson - son 8600 Lime Kiln Court, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/10/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Lue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ue to (or as a consequence of) ER Due to (or as a consequence of): Physician/Medical IF FEMALE: f yes, outcome of pregnancy □ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐Yes 2 ☐No 9 Unknown Completed by Be Certification: To

the death certificate be executed Division of Vital Records, P.O. Box 68760 attending ph ned by the a signed by The law requires has been si e 2 should l page certificate or Attending Physician:

physician and s the burial-transit After t death.

Funeral

Director

28a-f show

ral", or items 23a or 28a-f sh Exantine rust by notified

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examination institution.

Department of Health ar Important: If item 27 Is any Injury or other trau

Physician

/Medical

Examiner

permit.

Baltimore, Maryland 21215-0036

the Maryland

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital

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	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
SPINAL	STENOSIS 1 Yes 20 No 3 Probably 4 Unknown
HUDERIDE	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of D_ath 1 Natural 5 □ Pending 2 ∩ Accident investigation	(Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?
3 □ Suicide 6 □ Could not l 4 □ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) Type, Print) MERLYN

Medical

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

7801 32. Registrar's Signature

NOV 1 2008

VEMORYMO





6.EORGIA

29d. Date signed (Month, Day, Year)

227

SUITE

			State of Ma	ryland /				d Mental Hygi	ene	00000
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of L	Death	2. Date of Death	g. No. 2 U U Ö	35/68
	Physic		VILMA SKADIN JACOBS					Month Novemb	Day Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give street and number)	· · · · · · · · · · · · · · · · · · ·	-	4b. City, Town, or	Location of D		4c. County of Death	
			UNION MEMORIAL HOSPITAL			BALTI			N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Ain. (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
	ס		Usual Residence of Decedent	_ 01				JUL 1Z	1927 Mar	RYLAND
	arylar show	۲		10c. City, Tov						10d. Inside City Limits
	the M	recto	MARYLAND N/A 10e, Street and Number		BAL	TIMORE CI 10f. Zip Code	TY		- 077	1 X Yes 2 No
	h with	Funeral Director	633 Colorado Avenue				210	10	g. Citizen of What Cou USA	untry?
	ems 2	iner	14 Mac Decedent Ev	er in U.S.	13. \			? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examinal rest be notified at	by Fu	1 Never Married 2 Married)		☐Yes 2☐No	Specify:	derto Alcan, etc.)	Black, White Specify: WH	, etc. ITE
21215-0036	2 hour	ted k	3 XJ Widowed 4 LJ Divorced Year or Dates: 15. Decedent's Education	16	a. Deced	ent's Usual Occupa	ation	16	6b. Kind of Business/li	
215	thin 7; ee. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	——	(Give :	kind of work done d OO NOT use retired)	uring most of	working		-
21	filed within Hygiene. other than '	ပ္ပ	2		OME	1AKER			Own Resi	DENCE
Maryland	d be filed be to the ced of the c	Be	17. Father's Name (First, Middle, Last) ANDREW	Skadi	· NI		_	Name (First, Middle, Ma	*	
aryl	should and Mer marke	욘	19a. Informant's Name/Relationship (Type. Print)			Address (Street a		ABETH SKEI	BERDIS City or Town, State, Z.	in Code)
	and 2 ealth a n 27 is		Mr. Andrew Skadin (Neph			ACCENT C		_	LAND 20716	
ore	Pages 1 nent of Hu int: If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of cemete	of Dispos ery, crem	sition (Name of atory or other place))	Date 20	Oc. Location - City or T	own, State
altimore,		8	4 ☐ Donation 5 ☐ Other (Specify)	MOREL	AND	MEMORIAL	Park 1	10/14/2008	BALTIMORE,	MARYLAND
Ba	permit. Departr Imports any Inj		21. Signatur f Funcio Service de la compre		M	TCHELL-W	ÎËDEFEL		HOME, INC.	
			23a. Part 1. Enter the disease, or complications that caused the	ne death. Do	not ente	The mode of dying	OAD, in such as care	BALTIMORE, diac or respiratory arres	Maryland 2	21212 pproximate
	Physician		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	S						Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a death)	consequence	of):	-	255			IWEEK
	AND THE STREET	er	Sequentially list conditions, if any, leading to immediate but to for as a conditions.	KE)	VAZ	FAILUI	ee			WEEK
	cuted ad ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	E CI	ORDA	ARY AR	TERY	DISEASE		5 YEARS
Ö,	e exercian ar urial-tr		resulting in death) Last Due to (or as a c							10000
38760	ficate be executed physician and s the burial-transit	dical	d. VIATSE	TES	MEL	LITUS				10 YEARS
Box	law requires that the death certiff as been signed by the attending 2 should be detached for use as	CO3	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy					23d. Date of deliv	
M	e death	Physician/M	in the past 12 months? 1 ☐ Live birth 2 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti			Ectopic pregnancy Other (specify)			Month	Day Year
д О	that the de led by the detached	Phys	9 🗆 OUKHOWH							
ďs,	signe signe d be d	þ	Part II. Other significant conditions contributing to death but	not resulting i	n the un	derlying cause giver	n in Part I.		cco use contribute to t 2 ☐ No 3 ☐ Pro	
ecords,	w requir s been si should b	lete						24a. Was an		· · ·
Y	0 - 0	Completed						 autopsy performe 	prior to co death?	opsy findings available ompletion of cause of
Vital	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of D	1 ☐ Yes 2 To Death (Check only one)	ZNo 1 □Yes	2 ∐No
=	his light	မ	1 Yes 2 No Hospital: 1 patient				4 LI Nursing	g Home 5 🗆 Residence		fy)
o	ding Physith. th. After this continues of funeral directions	tion	27. Manner of Death 1 Matural 5 Pending (Month, Day,) 2 Accident investigation		Time of Injury	28c. Injury Work? M 1 7	at es 2 □No	28d. Describe how	injury occurred	
UIVISION	Atter er dea ector by the	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	- At home, fa	ırm, stre		2	28f. Location (Stree	et and Number or Rur	al Route Number.
5	Ital or Irs affe ral Dir	Cert						City or Town, S	State)	
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After t completely filled in by the funeral	Medical	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of the desired part of the part							
	To the within To the Somple	Med	one) and manner state 29b. Signature and title of certifier	J	_	29c. License	number	29d.	. Date signed (Month,	Day, Year)
			Nanikullarn, MD			AT2	4380	246 N	Overnber .	9 2000
	0		30. Name and address of person who completed cause of deat	th (Item 23a)	(Type, P	rint)		946 No	- 0, 2,	1,000
			31. Date filed (Month, Day, Year) 32. Registrar's) N ON	ME	MURIAL	- HOS	PITAL, M	5	
	Stat Registra		NOV 1 2 2008	Jigiladie	S. C.	a Charles				
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			1 - State of Maryland / [State Registrar		artment of F		nd Mental H	ygiene Reg. No. 2	008 35769
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of D Month	eath	3. Time of Death
No.	/Medio	cal	YVETTE KATHELEEN M. JONES 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	. I sestion of		4c. County	, 2008 1:30p
فمورس	Examir	ier	11 W. 20th ST.		BALTI		Death	,	/ A
	Funeral Director		033-40-1000	irthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, E 7 - 7 - 1	irth Day, <i>Year)</i> 1956	9. Birthplace (State or Foreign Country) NEW YORK
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Lo	cation				10d. Inside City Limits
	e Mary la-f sh liffed	ctor	MD. N/A BALT	TIM	ORE				1. Yes 2 No
	ith the	Director	10e. Street and Number		10f. Zip Code	_		10g. Citizen of	What Country?
	ns 23g	Funeral	11 W. 20th ST. 11. Marital Status 12. Was Decedent Ever in U.S.	13 \	2121		2 (Specify Ves or N	USA	ce - American Indian,
Maryland 21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	þ	Armed Forces? 1 🛣 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced Armed Forces? 1 📉 Yes 2 📆 No If Yes, Give Year or Dates:	1	fYes, specify Cuba		n? (Specify Ye's or N Puerto Rican, etc.)	Specify	ck, White, etc.
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	durina most o	f workina	16b. Kind of B	usiness/Industry
121	within ene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	life. E	ORS ASS	d)	9	MEDI	CAT
d 2	it Hy	Be Co	17. Father's Name (First, Middle, Last)	501	OKS ASS		Name (First, Middle	MEDI e, Maiden Surnan	
ylar	Q # Q 0	10 B	JAMES R. JONES			ВА	RBARA HA	LL	
Var	2 sho	e i	1				or Rural Route Num		
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of	of Dispos	sition (Name of	i	APT 3M M		AN, NY 10025 City or Town, State
altimore,	Pages nent of int: If ite		1 Burial 2 Cremation 3 Removal from State	ery, cřem	natory`or other plac REMATOR`]	MORE, MARYLANI
Balti	permit. Pages Department or Important: If i any injury or once.		21. Signature of Fundral Service License LONATHAN D. H	HIB	NER and Addre	ss of Facility	PHILLIPS	FUNER	
			23a. Part 1. Efter the disease, or complications that caused the death. Do r shock for heart failure. List only one cause on each line.						Approximate Interval Between
	Physician			my	locard	Tal.	infarc	t	Onset and Death
-1	/Medical Examiner		Due to (or as a consequence of	of):		fai	lure		2 local to
		je		reac	- CCI	(are		2 Monte us	
	acuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
8760,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of	of):					
687	ificate g phys is the	edical	d						
O. Box	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnance Other (specify)	у			te of delivery onth Day Year
rds, P.	w requires that to be the signed by should be detained by	ρ	Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause give	en in Part I.		tobacco use cont Yes 2 ☐ No	ribute to the cause of death?
Division of Vital Records,	The law re cate has be page 2 sho	Completed					24a. Was auto perfe	opsy ormed?/	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	nystcian: Thu nis certificate director, pag	Be (25. Was case referred to medical examiner?		lou		Death (Check only		
of	Phys er this eral dir	٦. ا	1 Inpatient 2 ER/Out	utpatient Time of	t 3 □ DOA Othe	4 L Nursi		idence 6 Oth	
ion	tending Ph leath. tor: After th the funeral	ation		Injury	Work	(?ື` Yes 2∐No	200. Describe	now injury occur	eu
Divis	safter des safter des sal Directo ed in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, stre	et, factory, office		28f. Location (City or To	(Street and Numb wn, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. p	Medical (29a. Certifier (Check only one) CertifyIng Physiclan: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	e, death	occurred at the tin restigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
	Voith Com	Σ	29b. Signature and title of certifier		29c. License	e number	49	29d. Date signed	d (Month, Day, Year)
	- 4	-	pr & Share, M.D.	7	D'	0556	5	Novem	mbe 11,2008
١	1	Dr	30. Name and address of person who completed cause of death (Item 23a) (Rong Zhang 3333 N. Calvart	(Type, P	rint)	Balo	timore.	, mo	whe 11, 2008
	Stat		31. Date fied (Month, Day, Tear) 32 Registrar's Signature	Kan	180 9	***			
	Registra	ar I	NOV 1 2 2008	S. C. Carlot	-				

DHMH 17 Rev 1/2001

		Please Type or Print in Black Indelible Ink. Ensure All		_	
	1	State of Maryland / Department of Health and M 1 - State Repistrar State of Maryland / Department of Health and M Certificate of Death		0000	00000
		1. Decedent's Name (First, Middle, Last)	Reg. I	2000	3. Time of Death
Physician /Medica	-	Chang Soo Kim	Vovember	Day Year 11 2008	4:45 AM
Examine	•	4a. Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death	4	4c. County of Death	1
		5. Social Security Number 6. Sex , 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgo!	place (State or Foreign
Funeral Director		212-02-3444 1 1 2 F 75 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	27 1932 Sol	uth Kovea
pu »	}-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryla f sho					1 No 2 No
ith the Mar	2	100. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	intry?
23a c	2	4521 East West Hwy #805 20814		USA	
fter death w ritems 23a	5	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ 106 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	
036 urs af urs af Exam	2	If Yes, Give 1 ☐ Yes 2 ☑ Mo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: A	3ian
Laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Marical Examinar marke notified at The Rocambles of by Europea Dispersor.	Clea	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Iffe. DO NOT use retired)	16b.	. Kind of Business/In	ndustry
within within ene.		Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS Man	To	nort/	Export
ind 2	5		(First, Middle, Maid	ten Surname)	
ylan vuld be Menta mrked artic ev		Mun Itwan Kim Up Xe	ee Har	K	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura	Route Number, Cit	11. 11.01	ip Code)
Te, Tand Healt Healt Sther 2	-	20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio	ate 20c.	. Location - City or T	own, State
Baltimore, Dermit. Pages 1 ar Department of Hear Important: If Item: any Injury or other		1 Surface 1 Surf	HAR D	Inel.	m
Balti permit. Departn Importa any inju	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	well Fu	ineral	Home
m 82 E # 8	4	Transtowell DY 10220 Gulford	Rd. Jess	sup, m	D 20794 Approximate
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final		~	Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Color Nary Anteny Due to (or as a consequence of):	D156 A3) E	
Examiner		Sequentially list conditions b.			
led led		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
60, be executed sician and burial-transit	EYall	that initiated events c			
De de Go	ē│				
Vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate ector: After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the fifted in T.O. Bo. Completed by Physicial Modification To Bo.		IF FEMALE:			
BO)		23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of deli- Month	very Day Year
hed by the adetached to	25	1 Yes 2 No 9 Unknown 9 Unknown			
IS, F	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
w requires seen seen seen seen seen seen seen s	ובח		1 Tyes		
Division of Vital Records, or attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be deathfreed.			24a. Was an autopsy performed	<pre>12. death?</pre>	topsy findings available completion of cause of
of Vital Re Invision: The Is his certificate ha I director, page 2	ے ا	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2 ☑ (Check only one)	∭No 1 □ Yes	2,EINo
hysici hysici this ce			me 5 Residence	e 6 □Other (Spec	:ify)
On of ding Phy. After thi funeral		1 🖾 Natural 5 □ Pending (Month, Day, Year) Injury Work?	28d. Describe how in	njury occurred	
VISIC Attent r death ector: by the	2	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office 2	28f. Location (Street	t and Number or Ru	ral Route Number,
Division of ' Ital or Attending Phys Its after death. all Director: After this id in by the funeral dif	<u> </u>	4 ☐ Homicide building, etc. (Specify)	City or Town, St	ate)	
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, a considerable of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within to the comple	100	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	n, Day, Year)
		busho 00057124	7	1/11/0	8
17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	مان کے صم	DIR	120814
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature	orgenown	i ra, De	irea, Ind
Registra	-	NOV 1 2 2008 Seem & James			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year KWON **Physician** 6:08 A.M HYUG NOVEMBER 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In vrs. last birthday) 1946 South **Funeral** Months 1 M 2 F UNKNOWN Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show Silver 1 Wes 2 No the Medical Examiner must be notified at Director Montgome 10g. Citizen of What Country? 10e. Street and Number 23a or USA 20906 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 2 10 1 Never Married 2 Married Yes Specify: ASIAN Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kwon ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) #3 WI 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Pisposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) or other place, Department of important: If it any injury or o 2/08 Baltimore rematoru 21. Si value of Funeral Service Licensee Funeral Howell 22. Name and Address A Facility Home 10220 Guil tord Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CARDIO PULMONARY /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to him edite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ittending physician and for use as the bunal-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 2 🗍 No P.O. I 9 TUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown ISCHEMIC CARDIO MYO PATHY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an IGA NEPHROPATHY autopsy performed Yes 2 2 certificate has 1 Yes 2 No 26. Place of Death (Check only one 25. Was case referred to medical examiner? director, Be Other: 4 \sum Nursing Home 1 Mnpatient 1 ☐ Yes 2 X No 3 DOA 5 Residence 6 Other (Specify) 2 ER/Outpatient မ after death. Director: After this 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. injury at Work? 27. Manner of Death Certification: Injury 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely f (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. 11/11/08 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ANGEL CHAN

31. Date filed (Month Pay, Year)

200

32 Registrar's Signature

2008

600 North Wolfe St, Baltimore, MD, 21287

		-	For State Registrar		State of Ma	aryland	-	artment of F r <i>tificate of</i>			ntal Hy	/giene Reg. No.	とせせる	35772	
			Decedent's Name (First,	Middle, La	st)					2	. Date of De			3. Time of Death	
	Physici: /Medic		Ronald Keit	h						12	ovent		2008	3 1:00 PM	
man is	Examin		4a. Facility Name (If not ins	_				4b. City, Town, o	r Location	Location of Death 4c. County of Death					
1			12031 Nort					Hager If Under 1 Year					ashingt		
	Funeral Director		5. Social Security Number 218-32-7110		Sex 7.Age	73	t birthday) Yrs.	Months Days	Hours	Min.	Date of Bi (Month, Di ept.1(Co	thplace (State or Foreign ountry)	
	and ww		Usual Residence of Deceder 10a, State 10b, C			10c. City,	Town or Lo	cation						10d. Inside City Limits	
	vianyli f sho	ğ	MD Wa	shing	ton	Нао	ersto	wn						1 □Yes 2 및No	
	the 728a	Director	10e. Street and Number	8	-	1146	CIBCO	10f. Zip Code				10g. Citizen of What Country?			
	h with		12031 Nort	h Sco	ttish Cour	t		217	40			USA			
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ☒ Widowed 4 □ Div		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 □Yes 2 ☑No			fy Yes or No can, etc.)	0-	14. Race - Ame Black, Whit Specify: W		
2-0	in 72 ho	ted	15. De	cedent's Ed	ducation ade completed)		16a. Dece	dent's Usual Occup	oation	ast of working		16b. Ki	ind of Business	Industry	
2	c = 3	Completed	Elementary/Secondary (College (1-4or 5	+)	`life.	DO NOT use retire	d)			Balt:	imore C	o. Schools	
2	73 (7) =		12				Main	tenance I		tment her's Name (i					
and	be be eve	Be	17. Father's Name (First, M)				l	reda V			Surname)		
Σ	d 2 should be the and Menta of is marked traumatic every	မ	William Ke		(Time Drint)		10h Maili	ng Address (Street	l				or Town State	Zin Code)	
Ma	d2s thai 7 is trau		Lisa A. Ho			r									
ည်	s 1 and 2 of Health Item 27 i		20a. Method of Disposition	Cilic	. Daugnee			esition (Name of matory or other pla		Dat			cation - City or	MD 21740 Town, State	
DOI	Pages nent of l		1 ⊠ Burial 2 □ Crem 4 □ Donation 5 □ Of					natory or other pla n Baptis:		11/12/	ี วกกล	l. Uin	door Mi	11, Maryland	
altimore, Maryland	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Eugeral S		-	11111							on Schw	ab Witzke	
Ba	Dep any any		1/2/1	m	M	1490) F	uneral Ho 630 Edmor	ome o	f Cato	nsvil	le, :	Inc.	MD 21228	
			23a. Part 1. Enter the dise.	ase, or com	plications that caused	the death.	Do not en	ter the mode of dyi	ng, such	as cardiac or	respiratory	arrest,		Approximate Interval Between	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Metastatic Color Control Control										Onset and Death 4 months		
	/Medical		resulting in death)		Due to (or as				1001						
	Examiner	L	Sequentially list conditions		b										
V	ed sit	in	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or as	a conseque	nce of):								
yo	xecut and I-tran	Examiner	that initiated events resulting in death) Last	1	c Due to (or as	a conseque	nce of):								
68760,	ficate be executed physician and s the burial-transit	la H		l	, d										
687	tificate ng phys as the	edical			u							- 1			
O. Box	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnation the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3[□ Ectopic pregnand □ Other (specify) _	су				23d. Date of de Month	olivery Day Year	
٠. ص	res that signed b		Part II. Other significant of	onditions	contributing to death b	ut not result	ing in the u	nderlying cause gi	ven in Par	tl.	23e. Did	tobacco i	use contribute t	o the cause of death?	
rds	quires nn sig uld be	d by						··			1 🗆	Yes 2	1 3 □ F	robably 4 Unknown	
of Vital Records,	aw requir as been s 2 should	Completed									24a. Was	s an opsy	24b. Were a	utopsy findings available completion of cause of	
Ä	: The law cate has page 2	E O									perf	formed?	death?	s 2 🗆 No	
ita	siclan: T certificat rector, pa	Be C	25. Was case referred to rexaminer?	nedical					26. Pla	ice of Death (
\$	hysic his ce I dire	2	1 Yes 2 No		Hospital: 1 ☐ Inpatie			III 3 LI DOM	her: 4 🗆	Nursing Hom	e 5 Aes	sidence	6 ☐ Other (Spe	ecify)	
n 0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □	Pending	28a. Date of Inju (Month, Da		8b. Time o	Wo	rk?	- 1	ld. Describe	how inju	ry occurred		
Sio	death. death. ctor: A	cati	Z L Accident	investigatio Could not b		At hom	o form at	M 1 Creet, factory, office]Yes 2		of Location	(Ctract or	nd Number or F	Rural Route Number,	
Division		Certification:	4 ☐ Homicide	determined	building, et	c. (Specify)	e, iaiiii, si	reet, factory, office			City or To	own, State	e)	igrar riodic resider,	
_	spital ours ours eral filled		29a, Certifier 1	ertifying P	hysician: To the best	of my know	ledge, dea	th occurred at the	time, date	and place, a	nd due to th	e cause(s	s) and manner a	as stated.	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral or within the completely filled in the funeral or within the filled in t	Medical	(Check only 2 M one)	edical Exa	miner: On the basis of and manner st	f examination	on and/or i	nvestigation, in my	opinion, o	leath occurre	d at the time	e, date an	d place, and du	e to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of	certifier				29c. Licen	se numbe	er		29d. Da	ate signed (Mon	th, Day, Year)	
			cynthe	a K	uttrec-Sa	nds.	20	D4-	1451			NOV	ember	7, 2008	
	3		30. Name and address of Cynthia Kut	person who	completed cause of o	leath (Item 2	23a) (Type,	Print) a Shine	g ton	Coun	ty. 7	47/	Vorthe	on Avenue	
	J		Cynthia Kut	ther:	Sands, mo	MOZPIC	- 0+	,,,	<i>'</i>	Hage	rston	مرمد	naryle	and 21742	
	Sta		OT. Date filed (month, Day		32. Registr	ar's Signatu	re	,							
	Regist	ar	NOV 12	ZUUS	13 Billiota .	18 6	Segal.	2							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. \angle Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November ANNA 06 2008 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/15/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2X F Days 81 216-20-0924 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County 1X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 228 S. CHester Street 21231 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X}\)No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Quality Control Paper Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Piechowiak Martha Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Conley Street Baltimore, Maryland 21224 Raymond J. Kosmicky, Jr. - Son 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place)
Saint Stanislaus
Cemetery Date 20c. Location - City or Town, State 11/10/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licenses 23a Part 1 Enter the disease, or common tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between snock, or heart failure. List only Immediate Cause (Final De to (or as a consequence of) abdominal gortic disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence or) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Hospital: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

attending physician and to I for use as the burial-transit The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 been signed by the a peen page 2 spital or Attending Physician: The law ours after death. eral Director: After this certificate has filled in by the funeral director, page 2 To the Hospital o within 24 hours aff To the Funeral DI completely filled in

Physician

/Medical Examiner

> Physician/Medical Š Completed Be မ

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/Medical

Examiner

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29b, Signature and title of certific

NOV

29a. Certifier

one)

Keith

Medical

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State Registrar

Follmar 31. Date filed (Month, Day, Year)

Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** AME KNIGHT 12:45PM 06 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYULEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Yrs. 10 25 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 1118 Vanguard Way #J 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ 3 Widowed 4 Divorced White permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Menta Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, It e Medical Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturing Incor/Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Knight ပ Margaret Kraft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Knight (Son) 3662 Emory Church Rd Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 11-10-2003 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensell Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION - A **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if uny, leading to in modulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physlcian: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 □Yes 1 Tyes 2 🗆 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2008

DHMH 17 Rev 1/2001

8

State Registrar

31. Date filed (Month, Day,

4940 EASTERN AVENUE, BACIMORE MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENOH

M.D.

32. Registrar's Signature

Ph D.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 Year **Physician** John W. Kafka 7:22p M Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 1000 Franklin Avenue Essex 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 DM 2 DF 218-30-6174 73 Director 3 1935 March MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, The Medical Exprins arms to retified at my or other traumatic event, The Medical Exprins arms to retified at 10c. City, Town or Location 10d. Inside City Limits 10h. Count 10a State Director MD Baltimore 1 ☐ Yes 2 ☑ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 1000 Franklin Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Roofer Construction 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Kafka Alberta Rosenthal ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Kafka / brother 3405 Wallford Drive Baltimore MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department c Important: If any injury or once. 1 ☐ Burlat 2 X Cremation 3 ☐ Removal from State Bayview Crematory: 11/10/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) al Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or conflictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) hymic /Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed 1eriptred and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ∏ Yes 2 ∏ No 3 Trobably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? las page 2 s certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide To the Hospital 29a, Certifier 1 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D 0005517 108 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) sebastion 10 JULA 3023 tastern 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Dhysis:		Registral	rtment of Health ar tificate of Death		Reg. No	200	18 3577
Physicia cal Exami		Floran	Kelly, J		Date of Death Month Day November 5, 2	Year	3. Time of Death 0330 hrs
		Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center	4b. City, Town, o	or Location of Death		c. County of Death	
Funeral		5. Social Security Number 6. Sex · . 7. Age (In yrs. last			8. Date of Birth(MM	(/DD/YYYY) 9. Birt	
irector		213-84-3336 1X M 2 F 47 Usual Residence of Decedent	Yrs. Months Da	ys Hours Min.	July 28,	Foreig	
ow any		10a. State 10b. County 10c. City, To	Town or Location				10d. Inside City Limits
tryland 8a-f show at once.	ctor	Maryland Baltimore 10e. Street and Number	10f. Zip Code	For	t Howard	tizen of What Cour	1 Yes 2 X No
ii ure iylaiylailu 3a or 28a-f sho iotified at once	Director	7515 Fort Avenue		21052		nited Sta	,
ted within / 2 hours arter death with the invaryante Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Ves XX No.	S. 13. Was Decedent of H		cify Yes or No-		ican Indian, Black,
aller or	<u>ک</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates	1 Yes 2X N			Specify: W	White
'natur Exam	ted r		16a. Decedent's Usual Occupa during most of working lif	ation (Give kind of work e. DO NOT use retired	k done 16b.	Kind of Business/I	Industry
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fental larked	o Be	Floran F. Kelly, Sr. 19a. Informant's Name/Relationship (Type, Print)	The state Address (Ch.		ret P. Mc	-	
두등일	입	Mrs. Tina J. Kelly (Wife)	19b. Mailing Address (Stree 7515 Fort A	ve. Fort I	Howard, M	Maryland	21052
ent of Health and the street of Health and the street of the street transmater transmate		1 X Burial 2 Cremation 3 Removal from State cre	lace of Disposition (Name of co ematory or other place)			Location - City or	Town, State
ment o		4 Donation 5 Other Spearing Holl	ly Hill Mem. (11/2008	Middle	River, MD
Depart Import injury		. na of Furer / Ser/o / Lights le	22. Name and Addres Duda-Ruc	k Funeral 1	Home of I	undalk,	Tnc.
sician		23a. Part I. Anter the Alease, or complications that caused the death, De	7922 Wis Do not enter the mode of dying	e Ave. Du	indalk M espiratory arrest, sh	arvland ock, rheart	Approximate Interval
edical miner		failure. List only one cluse on each line. Immediate Cause (Final disease a. Atherosclerotic					Between Onset and Death
IIII		or condition resulting in death) Due to (or as a consequence of):					
	je l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
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and transit		d.					
S = =	Medical	X UNPENDED AMENDED 23a,27,pc	_	/18/08 TT			
ig phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		Ectopic pregnancy		d. Date of delivery	
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signed by be detac	by	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause	given in Paπ ι.		✓ No 3 Prob	the cause of death? Dably 4 Unknown
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te has l ige 2 st	Jupi	· · · · · · · · · · · · · · · · · · ·			autopsy performed?	prior to o death?	completion of cause of
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this certi	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ EF		Other Nursing H		ence 6 Other	
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death.	catic	2 Accident Investigation		Yes 2 No			
ours after d	Certification:	3 Suicide 6 Could not be determined (Specify)	ne, farm, street, factory, office l	uilding, etc. 28t	f. Location (Street a or Town, State)	ind Number or Rui	ral Route Number, City
_ = _	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner:On the basis of examination and/eand manner stated.					
witi Con	Me	29b. Signature and title of certifier	29c. Licens	e number	29d.	Date signed (Mon	nth, Day, Year)
37		M. Hand Steep of doubt (Hom 2)		M.E.	Nov	vember 5, 200	8
0	20. 21		111 Penn Street, Bal	timore, MD 2120)1		
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	book				
		110	-	-		001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death New En B **Physician** Charles В. Kirby 12:55AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Tate Hospice House Linthicum Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 17, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 88 214-12-4626 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Examinational Examination ange. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 N. Longcross Road 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 📉 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Supervisor U.S. Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Howard Kirby Elizabeth Stark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8021 Foxtail Lane Glen Burnie, MD 21061 Mr. James Kirby/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. Date 12 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2008 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 MOHZI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** My clodys plastic

Due (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events je Due to for as a consequence of) Examir burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery To the Hospital or Attending Physician: The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at it. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Nea,

3altimore, Maryland 21215-0036

Box 68760

P.0.

of Vital Records,

Division

29d. Date signed (Month, Day, Year)

NOVEMBER 10, 2008

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OlVeleyan

		•	1 - For State Registrar	State of Ma	ryland / De	partm ertific	ent of l	Health and N Death	Mental Hy	/giene2	J 0 8	35778
			1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		Gary	James		Kuh	1		Novemb			3:00 A ^M
3	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b.	City, Town,	or Location of Death			nty of Death	
			425 Rose Avenue			G1	en Bu	rnie		Anı	ne Aru	ınde1
P;	Funeral Director		5. Social Security Number 215-46-9146	Sex 7. Age	60 Yrs	Mor	nder 1 Year iths Days		8. Date of B	irth 14,4 ^{Yea} (1948	9. Birth Cou Mary	place (State or Foreign ntry) 1 and
	P. J.		Usual Residence of Decedent									
	ith the Marylan or 28a-f ehow	tor	Maryland Anne Ar	undel Co.	Glen l							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28,	lrec	10e. Street and Number			10	f. Zip Code			10g. Citizen		•
	23a c	a	425 Rose Avenu	ie				21061		Uni	ted St	ates
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-f ehow other treumatic event, the Modical Exeminar mark to notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates:	Ever in U.S.		ecedent of specify Cubes 2/2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		Race - Ameri Black, White city: Wh	
8	tural	ed	15. Decedent's E		16a. De	cedent's	Usual Occu	pation		16b. Kind of	f Business/Ir	ndustry
1215	within 72 iene. then na	Completed	(Specify only highest grant (0-12) 12 yrs.	College (1-4or 5	+) (G	ive kind o e. DO NO	of work done OT use retire	during most of work od) Attendan			MTA	,
Maryland 21215-0036	d 2 should be filed with and Mental Hygiene 7 is marked other the treumatic event, Ins.	To Be Co	17. Father's Name (First, Middle, Last, William Kuhl)				18. Mother's Nam Elizabe			name)	
ary	shound M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Add	iress (Stree	t and Number or Rui	ral Route Numi	ber, City or Tox	wn, State, Zi	p Code)
ž	1 and 2 Health a em 27 ie		Mrs. Susan A. Kuhl	/Wife	425	Rose	e Aven	ue Glen	Burnie	Mary1	and 2	21061
Baltimore,	an U = -		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	Removal from State	20b. Place of Dicemetery,			ice)	Date	20c. Locatio	on - City or T	own, State
Baltii	permit. Pag Department Important: i eny injury o		21. Signature of Funeral Service Lice	Micha	el E.	22. Nam	e and Addr		ngletor	Funer	a1 & 0	Cremation
4	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Ganappy plications that caused one cause on each in	the death. Do not	enter the		ng, such as cardiac				Approximate Interval Between Onset and Death
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8760,	cate be executed obly sicien and the burial-transit	ilcal Exa	resulting in death) Last	Due to (or as a	a consequence of):							
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		oic pregnancer (specify)	y			Date of delive	very Day Year
	tuires that π signed b	by	Part II. Other significant conditions of	contributing to death bu	at not resulting in th	e underly	ing cause g	ven in Part I.		tobacco use c	1.	the cause of death?
Vital Records,	0 - 5	Completed							per	opsy ormed/2	death?	opsy findings available ompletion of cause of
tal	ician: Th certificate rector, pag	a)	25. Was case referred to medical					26. Place of Deat	1 Yes	2 No	1 🗆 Yes	2 No
	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatie	nt 2 ER/Outpa	tient 3E	7.004 0:	her: 4 \(\sum \) Nursing Ho		sidence 6 🗀	Othor (Saco	.6.1
on of	ding After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day		e of	28c. Inju			how injury oc		
Division	i Pitte	Certification:	3 Suicide 6 Could not be determined	o, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)				ral Route Number,				
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Certifying Ph (Check only ons)	nysician: To the best of miner: On the basis of and manner sta	examination and/o	eath occur r investiga	irred at the t ation, in my	ime, date and place, opinion, death occur	and due to the	e cause(s) and , date and place	manner as	stated to the cause(s)
	To the within 3	Me	29b. Signature and little of certifier				29c. Licen	se number		29d. Date sig	ned (Month	. Day, Year)
				7			Doos	57984		Novem	per E	1 2008

State Registrar

DHMH 17 Rev 1/2001

LUIS DIAZ

31. Date filed (Month, Day, Year) NOV 1 2 2008

30. Name and address of rison who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RM 590 CRBI BALTIMORE, MD 21231 1650 ORLEANS ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 10:56 a M Ellen Kimbalana November Christopher 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 8704 Allenswood Road Randallstown | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | MAY 30 1947 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕇 F Months 212-46-5760 61 Maryland Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Eberle Drive, Apt. 102 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Matthews Onnefronzes Donzel Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chano Kimbalana - husband 6638 Eberle Drive, Apt. 102, Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/10/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Serget Licensen, H. Williams Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD HULL 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 120011 Jam 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 ₽No 2 No 1 □ Yes 1 Tes 25. Was case referred to med 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence 1 □ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Lath 28h Time of 28d. Describe how injury occurred 1 Intural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

if than "natural", or items 23a or 28a-f show the Wedical Eventieur must be notified at

Director

Funeral

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Completed

Be

2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

7 is marked other traumatic event,

Department of Health Important: If item 27 any injury or other troone.

Health a

Baltimore, Maryland 21215-0036

burial-trar

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

and attending physician for use as the buria ed by the a signed by the peen has certificate director,

funeral e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera After 1

Physician/Medical þ Completed Be Certification: To

State Registrar

24 hours a Funeral I

To the within 2

Medical

3 Suicide

29a. Certifier (Check only

4 Homicide

29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person VII

31. Date filed (Month, Day, Year. 32. Registrar's Signature

6 Could not be

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

08-08373 Ziona Llovd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Programment of the programment o	lona	Lioyu		1- For State Control of Pleating and A Department of Pleating and Certificate of Death	d Mental Hygiene	Reg. No. 200	18 35780
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) November 9, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		T S S S S S S S S S S S S S S S S S S S	네 높다			✓ Yes 2 No 1 ✓	
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· V		1 Drug.	1		more, MD 21201		
Registrar RUV 1 2 2000 4		S	tate	31. Date filed (Month, Day Year) 108 22. Registrar's Signature			

ORIGINAL

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modical Evernine must be notified at ange.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of Ma	aryland /	Depa	ertment c	f Healtl	h and N	/lental Hy	gien	е		0 17 71	
	1 - State Registrar	Cer	ertificate of Death				Reg. No. 2008 3578						
	1. Decedent's Name (First, Middle, Last)			Date of Death Month Day Yea			nar.	3. Time of De	eath				
an al	WILLIE LUC			November 5 200				06:58	М				
er	4a. Facilify Name (If not institution, give s	street and number)			4b. City, Tow	n, or Location	on of Death		40	. County of I	Death		
	GILCHRIST HOSPICE				TOWSON					BALTIMORE CO			
	5. Social Security Number 214-22-7748 Usual Residence of Decedent	oirthday) Yrs.	Month Day Year)					9. Birthplace (State or Foreign Country) NORTH CAROLIN					
	10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City	Limits
to	MARYLAND HARFOR							1 □Yes 2	ONX]				
Funeral Director	10e. Street and Number	EDGEWOOD 10f. Zip Code				10g. Citizen of What Co				ntry?			
교	528 BURLINGTO		21040				U.S.A.						
ner		ver in U.S.				spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)			14. Race - American Indian,				
	1 Never Married 2 Married	Armed Forces? 1				o Alcan, etc.)		Black, White, etc.					
d b	₩Widowed 4 Divorced				□Yes 2🛛			Specify: BLACK					
Completed by	15. Decedent's Educ (Specify only highest grade	a. Deced	lent's Usual O	cupation	nost of work	16b. Kind of Busin			ess/Industry				
Jdu	Elementary/Secondary (0-12)				(Give kind of work done during most of work life. DO NOT use retired)					,,,,			
ဝိ	unknown			SE	CURITY	1				ECURIT	Ϋ́		
Be	17. Father's Name (First, Middle, Last)							ne (First, Middle, Maiden Surname)					
2	CHIRNER DEE MAGGIE LEAG												
	19a. Informant's Name/Relationship (Typ	,	15					ral Route Numb		,		,	
	Donnell Lloyd/Son 20a. Method of Disposition	1	OOb Disease					Idgewood					
	1 XX urial 2 ☐ Cremation 3 ☐ R	ceme	tery, crematory or other place)				Date 20c. Location - City or Town, S				wn, State		
	4 Donation 5 Other (Specify) HOLLY HILLS MEMORIAL 11-10-08 MIDDLE RIVER, MARYLAND												
	21. Signature of Funda Soft (1975) See WILLIAM C BROWN COMM FUNERAL HOME-HARF 321 S PHILADELPHIA BLVD, ABERDEEN, MI								ORD, P. 21001	Α.			
	23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										en		
	Immediate Cause (Final disease or condition resulting in death) a. District NephroGastry Due to (or as a consequence of):									Onset and Dea			
	resulting in death)	consequenc	equence of):										
_	Sequentially list conditions.	b											
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):											
Examiner	that initiated events resulting in death) Last	Due to for as a consequence off:											
Ē		Due to (or as a consequence of):											
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/Me	IF FEMALE:	of pregnancy	2014										
ian	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)						23d. Date of delivery Month Day Year				
ysic	1 ☐Yes 2 MNo 9 ☐ Unknown	5 L											
Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								ite to th	ne cause of dea	th?		
d b	Round roscul		, ,	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno					known				
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ပိ	25. Was case referred to medical examiner? Hospital: Check only one)										2 🗆 No		
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tion	Natural 5 ☐ Pending	Year)	Injury Work?				28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,						
fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str											
Certi	4 ☐ Homicide determined	building, etc	g, etc. (Specify)				City or Town, State)						
Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 29c. License number							er	29d. Date signed (Month, Day,)				Dav. Year)	
	1 Oleans												
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within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) ATPLES 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Towson MD Z1204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per in g885 11-14-08 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8 2008 <u>11:</u>15₽™ Gregory Thomas Lynch /Medical 4a. Facility Name (If not institution, give street and number)
Arlington West 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Date of Birth (Month, Day, Year)
9-11-1947 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral ™** M 2□F 226-60-0690 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No N/A Baltimore MD Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA "natural", or items 23a 5112 Harford Road Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Julia Lynch James Peter Rice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1707 Abbotson Street Balto, MD 21218 Carolyn Jones-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) $11 - \frac{10}{10} - 08$ Mt Zion Cemetery Lansdown. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Balto, MD 21202 Immediate Cause (Final disease or condition resulting in death) Physician me tas to he Parain /Medical Due to (or as a consequence of) Examiner y ear Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lung Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes No certificate has page 1 ☐ Yes 2 ☐ No 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation or Attending 1 Natural Injury To the nospinal within 24 hours after death.

To the Funeral Director: After the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in b 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11.11.08 043386 رسن 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Dani-1 1 toward Pluce Bulbinove 1714 ELLW 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 12 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 9:20 AMM /Medical 2008 Dora Donna Leitch November 8 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Harford If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F Director 56 09/22/1952 215-64-8569 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedical Ever, increwed by notified at 1 🖟 Yes 2 🗆 No Funeral Director Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 610 Wendellwood dr United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked ot any injury or other traumatic ever ၉ Edward Sniadach Mary Cerasoli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Leitch/Husband 610 Wendellwood dr. Bel Air, MD 21014 Baltimore, Pages 1 ament of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Nov 10 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory

22. Name and Address of Facility 2008 Beltsville, Maryland 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Manual and Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiac arrest **Physician** /Medical Due to (or as a consequence of): 2 hrs Examiner Hemorrhagic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 PNo 2 **1**No 1 □ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖰 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Records, sion of Vital 24 hours after death Funeral Director:

November

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

hil asri



29c. License number

163420

29d. Date signed (Month, Day, Year)

November 8, 2008

Division of Vital Records, P.O. Box 68760, e Funeral Director of Fune within 2.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature FOH BOON 7601 OSLER DRIVE TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) State No construction Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2008 Month **Physician** () V /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ICHCIS 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex urity Number **Funeral** Months Days Hours Min 1 □ M 2 F 220-16-1665 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, It a McGlical Examinat must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No MD Koseda TI MORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No ۵ Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omemaker home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ evens 19b. Mailing Address (Street and Number of Rural Route Number, Cia or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08 TOREST HIL 22. Name Address of Facility 21. Signature of Funeral Service Licenses BALTIMORE, MD 2123 Kunber 1064 Evans Funeral Chapel 23a. Part 1. Enter the disease, or con pications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death LUNG CANCER W/Metastase Immediate Cause (Final NONSMAU **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Soque thely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed K E Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the 9 ☐ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? certificate 2 □ No 1 ☐ Yes 1 ☐ Yes this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 2003

Registrar

State

(0:25AM

555 W.

32. Registra 's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

taulkner MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year UPDIKE OPENCE 10:37A M OVEMBER 2008 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death 10G WOOP SURNIE UNDEL 8. Date of Birth (Month, Day, Year) March 23,1919 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕏 F Months Days Hours Min 215-07-4405 89 MD Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Dogwood Drive 21061 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₺ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MD Elementary/Secondary (0-12) College (1-4or 5+) Social Services 12 Stenographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Elmer Griffith Dorothy Roberta Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Roberta Croney/Daughter 507 Dogwood Drive Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenson 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Inset and Death Immediate Cause (Final ADVANCED disease or condition resulting in death) VEARS Due to (or as a consequence of): Due to for as a consequence off: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☒ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Worldon Expriner must be really dist

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: (I flem 27 is marked other than "natural", or items 23s any injury or other traumatic event. If—Wenter

Baltimore, Maryland 21215-0036

Box 68760

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of Vital Records,

Division

/Medical

10a. State

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Completed by Physician/Medical IF FEMALE: 9 Unknown

2 No 3 Probably 4 Unknown 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 2 No 1 ☐ Yes 1 □ Yes

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only ope)

29b. Signature and title of certifier

5 Pending investigation

6 □ Could not be

determined

046360

1 ☐ Yes

29d. Date signed (Month, Day, Year)

State

Be

Medical Certification: To

address of person who completed cause of death (Item 23a) (Type, Brint)

and manner stated.

nth, Day, Year) 32. Registrar's Signature 2

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G887, 1/21/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. ZUU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2008 ROBERT ANDREW LONGEST, SR. NOV 2:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3428 ELM AVE. BALTIMORE 5. Social Security Number 5918 219-26-5418 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min. 69 Director MAY 22, MD 1939 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, Its Medical Examinar must be ruffilled at **Funeral Director** 1X Yes 2 □ No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3428 ELM AVE 21211 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Specify: WHITE If Yes, Give Year or Dates: 1 □Yes 2 X No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH **MECHANIC** DAIRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked o 2 ROBERT LONGEST MARGARET GEER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21211 JUDY LONGEST 3428 ELM AVE., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/07/2008 | BALTIMORE CO., MD LORRAINE PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1 Enter the Part 1 Enter the disease, or shock, or heart failure. List disease, or complications that caused the de Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** emeu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical ate has been signed by the attendir page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 □ No 2 □+No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 - Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

UB S ROT 29c. License number 0 48

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

C

32. Registrar's Signature

	•	For State of N State of N Registrar	larylan	-	artment of He <i>rtificate of D</i>			giene Reg. No. 2 ()	08	35788	
Physicia /Medica		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day		3. Time of Death 3. Time of Death	
Funeral Director		4a. Facility Name (If not institution, give street and number) Howard County Ceneral Hospital 5. Social Security Number 6. Sex 131–22–5961 Usual Residence of Decedent			4b. City, Town, or Location of Death Columbia t birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			4c. County Howeth (1), Year) 28, 1927	9. Birthplac Country New You	ace (State or Foreign	
with the Maryl Ba or 28a-f sho	Direc	Maryland Howard 10e. Street and Number 6437 Belleview Drive			Columbia	1016		1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?			
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinations the northed at	by Funeral	11. Marital Status 1 Narital S	?		Uses Decedent of His Was Decedent of His of Yes, specify Cuban, Uses 250 No	LO46 panic Origin? (S , Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: Asian			
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical E-ann traumatic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			stry	
laryland 2 should be file and Mental Hy is marked oth aumatic event	To Be (17. Father's Name (First, Middle, Last) Tow Wy Yee 19a. Informant's Name/Relationship (Type. Print)	Houe			ne (First, Middle, Maiden Surname) SY See Iral Route Number, City or Town, State, Zip Code)					
Baltimore, Ma bermit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tran		Elizabeth Low (Daughter) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		6437 B	elleview Dri sition (Name of natory or other place)	ve Colum	bia, Mary Date	land 21046 20c. Location -	5		
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Name and Address itzke Funera 555 Twin Kno	of Facility 1 Homes, 11s Road	Columbia	Glen Burr Maryland		yland	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or a	fre.	w (er the mode of dying,			rrest,	l In	Approximate Interval Between Onset and Death	
68760, fiftcate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a:	T. i-ti-								
the death certific ty the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown				ate of delivery lonth Day Year					
cords, requires the been signe should be disposed.	ompleted by Pr	Part II. Other significant conditions contributing to death Differ Fes Hyper Few significant conditions	in Part I.	1 ☐ ¹ 24a. Was autoj	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
- ' @ O 14	lo Be Co	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpat	1 □ Yes th <i>(Check only c</i>	1 Yes 2 No 1 Yes 2 No (Check only one) ne 5 Residence 6 Other (Specify)							
ding P. Affer funer	ertification:	27. Manner of Death 1 Natural 5 □ Pending (Month, Directly and Death (Month) and Death (Month) and D	28b. Time of Injury	28c. Injury a Work? M 1 □ Ye	28d. Describe how injury occurred						
y at a se le	٦ ١	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time,					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hos within 24 h Completely	Medical									he cause(s)	
	29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walt Affus MD 5755 (Edg. Colon bis, MP 2104) 31. Date filed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 1005 J 35							of			
State Registra		31. Date filed (Month, Day, Year) 22. Regist NOV 1 2 2008	rar's Signat	E JA	n Chus	e, Co	lum	Six,	TO O	11044	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#3perPHYS . 6885 11 / 13 / 08 WS State of Maryland / Department of Health and Mental Hygiene [] [] 8 Certificate of Death 20 To Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** MANUEL CELAYA nov ember , 2008 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | January 1, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 262-70-8774 Director 78 Yrs. Cuba Usual Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insportant: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exemptor. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Florida 1 XXYes 2 □ No Dade Miami 10e. Street and Number 10f. Zip Code 33196 10g. Citizen of What Country? 9408 SW 156th Place USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1XXYes 2□ No Specify: ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced Cuban White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gracian Celaya Alicia McCulloch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1007 Bellemore Road Baltimore, Maryland 21210 19a. Informant's Name/Relationship (Type, Print) Jorge A Celaya Son 20a. Method of Disposition
1 ☐ Burial aXX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GreenMount Crematory Nov.11,2008 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMitchell-Wiedefeld Funeral Home Inc gnature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ung CANCER **Physician** 6 months /Medical Due to (or as a consequence of): Examiner PREUMORIA 1 WEEL Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 □Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 [
28a. D te of Injury
(Month, Day Year) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation death. filled in by the fi 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ate, medical doctor RES-000 november 9,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 JOHNS HOPLIAS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MARYLAND MIKHAILIA LAKE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 10, 2008 D. Merton Mears 11:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4519 Montgomery Road Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min 1 X M 2 □ F Director 216-07-3650 May 30, 1908 Virgínia 100 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4519 Montgomery Road 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White 2 Specify: 3 NWidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otho Mears ၉ Monnie Cobb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garland E. Mears 1049 Ramsgate Court; Winter Park, Florida 32792 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem.Park 11/15/2008 Elkridge, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Pervice Licensi 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CHRONIC RENAL FAILURE 10 years resulting in death) Due to (or as a consequence of) ONGESTIVE HEART FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit Exami ATHEROSCUEROSIS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

and

attending physician certificate be

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certificate

this

Physician:

al or Attending P s after death.

Hospital

the

Box 68760

P.O. |

or Vital Records.

Division

within 72 hours after death

ss 1 and 2 should be filed within the Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

9 Completed director, Be မ funeral

Certification: in by the

within 24 hours after death.

To the Funeral Director: After 0 State

filled

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 2

2008

DAUID

30. Name and address of person who completed cause of death (New 23a) (Type, Print)

LEICHTLING

1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1□ Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

5500 Knoll North, Columbia, MD 21045

DHMH 17 Rev 1/2001

Registrar

M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08365 State of Maryland / Department of Health and Mental Hygiene John Francis Mudd 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month November 7, 2008 **Medical Examiner** John Francis Mudd c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 1532 Langford Road Gwynn Oak 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min. Months Days Hours Director 220-22-4734 1 X M 2 F 15 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location , or items 23a or 28a-f show r must be notified at once. Maryland Baltimore Woodlawn after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1532 Langford Road 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status Was Decedent Ever in U.S. Armed Forces? Never Married Married 2 X No Yes 3 X Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify:

2 hour "natu	þe	15. Decedent's Education (Specify		during most of wor				Olie I	ob. Kiliu	Of Business/iii	uusuy
JUSD within 72 hour iene. er than "natu	olet	Elementary/Secondary (0-12)	College (1-4 or 5+)		_				T . C	-	
5, MD Z-1Z-15-0U-36 and 2 should be filed within 72 hour lealth and Mental Hygiene. tem 27 is marked other than "natu traumatic event, the Medical Exan	Completed			Insurance	Age		1 (F)	NACOUT NO		e Insur	ance
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1 be f l be f ental nrkec	Be	John A. Mudd			لب	Carol	ine H	lorney			
hould hould hould hould his ma	2	19a. Informant's Name/Relationship		19b. Mailing Address							
JOFE, MU ages 1 and 2 shount of Health and 1 it. If item 27 is 10 other traumatic		JoAnne Harris	Daughter	13746 Bar	ber	ry Way	; Syk	esvil.	le,	<u>Marylan</u>	d 21784
Fites Team		20a. Method of Disposition 1 Burial 2 XCremation 3		Place of Disposition (Nar crematory or other place)		metery,	Date	e 2	20c. Loc	ation - City or T	own, State
		4 Donation 5 Other Specif	A L	lantic Crema		v 1	1/12/	2008	G1e	n Burni	e. MD
		21, Signature of Funeral Service Lice	7			s of Facility	Sterl	ing As	shto	n Schwa	b Witzke
Balt permit. Departi Import injury		Mrsk Hair	ensee Molos	SU Funera	1 H	ome of ndson A	Cato	nsvil]	Le,	Inc.	MD 21228
Physician		23a. Part I. Enter the disease, or con	nplications that caused the death	n. Do not enter the mode	of dying	, such as cardi	liac or resp	iratory arrest	t, shock,	or heart	Approximate Interval
/Medical		failure. List only one cause on	each line.								Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Contact Shotgun Wou								2000
		or condition resulting in death)	Due to (or as a consequence of	or):							
	J.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):		_		_			
	nin	cause. Enter Underlying Cause	C.								
. .	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):							
outed nd ransi	Ē		d								
te be executed ysician and burial - transit	ica	UNPENDED	AMENDED								
by sic	Physician/Medical	F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver									
tificate ng phy as the t		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3	Ectopic pr	regnancy		Мо	onth D	ay Year
X 68/ th certific trending process to	ici	4 Pregnant at time of death 5 Other (Specify)									
BOX 68 / 60 e death certificate b the attending physi ed for use as the bu	hys		9 OTKHOWII								
UIVISION OF VITAL RECORDS, P.O. BOX 68/60, the Hospital or Attending Physician: The law requires that the death certificate be executed that 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial - transi	by P	Part II. Other significant conditions	s contributing to death but not i	resulting in the underlying	cause	given in Part I.	l.				he cause of death?
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ords, v requir s been s should	Completed							24a. Was an autopsy			opsy findings available impletion of cause of
CO e law e has e 2 s	μ		*			_	_	perform	ed?	death?	
VITAI RECOTGS, hysician: The law require this certificate has been si I director, page 2 should b	ပိ				00 51	f D+h (Oh		Yes 2	No	1 🗸 Yes	8 2 No
certi certi	Be	25. Was case referred to medical examiner?	Hospital:			e of Death (Ch Other:				e 6 V Other:	0
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ling Ph After t	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury FOUND:		ury at Work?	Sub	Describe ho		occurrea	
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DIVISION OF ital or Attending Pl irs after death. al Director: After lled in by the funera	jį.	3 ✓ Suicide 6 Could no	28e Place of Injury - At h	nome, farm, street, factor	, office	building, etc.		Location (Str or Town, Sta		Number or Rur	al Route Number, City
ital Illed	Certification:	4 Homicide determin	ned (Specify) Single Far	mily Home						Gwynn Oak, M	MD .
Hosy 24 hc Fum tely f	<u>a</u>	29a. Certifier 1 Certifying Phys	ician: To the best of my knowled	dge, death occurred at the	time, o	late and place,	, and due	to the cause((s) and n	nanner as state	d.
	edical	one) 2 Medical Examin	er:On the basis of examination a	and/or investigation, in m	y opinio	n, death occur	rred at the	time, date ar	nd place	, and due to the	e cause(s)
wit Con	₩	29b. Signature and title of certifier	and mariner stated.	29	c. Licen	se number			29d. Dat	te signed (Mor	th, Day, Year)
5		1///	•			.M.E.			Nover	mber 8, 200	8
00145		30. Name and address of person wh	a sampleted anyon of dooth (lton	m (22a)							
OCME			eputy Chief Medical Exa		Stree	t, Baltimore	e. MD 2	1201			
			32. Registrar's Signat		3400	.,	J, Z				<u> </u>
S Regis	tate	31. Date filed (Month, Day, Year)	52. Registrar's Signat	£							
		NOV 1 2	2008	S Graffa Ji		-					
MH 17 Rev 1/ ME 2006	2001			ORIGINAL							
2000											

Time of Death

1604 hrs

Foreign Country) Maryland

14. Race - American Indian, Black,

White, etc.

Specify: White

10d. Inside City Limits

1 Yes 2 X No

Physiciar	Ì
/Medica	
Examine	į

Funeral

Director or items 23a or 28a-f show

3altimore, Maryland 21215-0036

Physician /Medical Examiner

physician and

traumatic event, the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or Department of Health ar Important: If item 27 is any Injury or other trau To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

P.O. Box 68760.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 2008 ear November 9, Helene M. Martinez 5:10 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5411 Wather Avenue N/A Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/12/1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 💆 F Months Days Hours 88 214-18-6301 Unk Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 □ No **Funeral Director** Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5411 Wather Avenue 21214 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1_ Never Married 2 Married 1 ☐Yes 2 XNo Specify ģ White Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Fye-Sinkler - Caretaker 5411 Wather Avenue Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Carmel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL ALUTO disease or condition resulting in death) Due to (or as a consequence of): HBNOSCLENOTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) N-K. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 OSTEDANTHAITIS HYDERTGOSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Majon DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 Yes 2 No N. 4 -25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and time of condition 29d. Date signed (Month, Day, Year) 29c. License number 00017148 11-11-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONATO A. VANGAS, JA, MO BALTIMONE 4706 HARROND 20. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2 2008

Amend #31 per DVR g885 11.12.08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 **Physician** 06 2008 4:02 p M Muzzetta Morris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2843 Edgecomb Circle North **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 08/09/1926 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min South Carolina 82 Director 227-56-2771 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at Director 1 XYes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2843 Edgecomb Circle North 21216 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ģ Specify: Black 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any Injury or other traumatic event, I'm. Once. 10 years Home Maker Domestic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Thomas Samuel Margaret မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Steele/ Daughter 6684 Star Path, Columbia, Md, 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roosevelt Memorial Park 11/11/2008 Chesapeake, VA 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor St. Balto, Md 21217 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ع) ~e -10 rec /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical COLONA IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ned by the a detached to P.O. 9 Unknown been signed I should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform 2 🗆 No 1 ☐ Yes 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 21 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28244

State Registrar 30. Name and address

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

death (Item 23a) (Type, Print)

chan

32. Registrar's Signature

person who completed cause of

10298 Balto Nat 1. P. Ke Ellicott Cit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 5:22 PM November 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Maryland Georges Douthern Hospita ince linton 9. Birthplace (State of Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 260.22-2576 Months Days Hours 108M 2 F Yrs. Director December 22, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show emple 1 ☐ Yes 25 No Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Old 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 ō þ 1 □Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced "natural" Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retire during most of working Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygin is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchell Kamba ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Arlington, Virginia Mitchell Don Fillmore St. 22204 Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State Department of H Important: If Iten any injury or oth once. 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Annandale, Virginia Pleasant Valley Memorial Park 11 4 ☐ Donation 5 ☐ Other (Specify) 22. Mme and Address of Facility 21. Signature of Funeral Service Licensee ral Service 2605 S. Shirlington Rand Arlington leg 2222 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nyocardialir Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? After this certificate 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and tire of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surratts Road Clinton andra MD

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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KS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Volvenber (4, 2008)

4c. County of Death Month **Physician** Patrick Marsh /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner N/A nacyland General ltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/10/1948 5. Social Security Number Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Mary Land 212-52-7493 60 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 54 West Talbott Street 21227 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinen aney. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Electric 12 Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth E. Marsh Leah T. Morris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2235 Marlborough Drive, York, PA 17403 Mary Dasch, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Svc. Corporation 11/11/2008 Towson, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. answord 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one are son each line. Immediate Cause (Final iratore **Physician** disease or condition resulting in death) /Medical Examiner Mumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, use as the burial-trans attending physician and The law requires that the death certificate be exec Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the aid be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 2 **1** No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Corneral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) Day 7, 2. Date of Death 3. Time of Death **Physician** Edward Joseph Miller, Sr. 5:25 A M November 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Stella Maris Hospice Center Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours Min 1**X**□ M 2□ F 1,1916 Maryland Director 213-20-6336 Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c City Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sl Injury or other traumatic event, the Medical Examiner must be notified 1 ☐Yes 2KINo Director Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 Funeral 322 Choice Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 2 Specify: 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) 9 Years Nursery Owner/Operator Colgate Nursery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John C. Miller Matilda Rutkowski ပ and M 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a LuAnn Miller (Daughter) 82 Farcorners Loop Sparks, Maryland Department of Heal Important: If Item 2 any injury or other once. 20a, Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St / b ☐ Other (Specify) Sagred Ht. of Jesus Cem. 11/10/2008 Dundalk, Maryland 4 ☐ Dopation 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIVE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □Yes 2 No 2 **N**No □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner'

altimore, Maryland 21215-0036

VUVE MOCR

Division of Vital Records, P.O. Box 68760, certificate funeral director, this e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the After 1 filled in by the

Be Certification: To

2 Accident 3 Suicide 4 Homicide Medical 29a. Certifier

1 ☐ Yes

2 No

27. Mann of Death 5 ☐ Pending investigation

6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

VALLEY RD TIMONIUM, MD 21093

Other: 4 Nursing Home 5 Residence

2	
b. Signature and titly of certifier	
1.11	111
CAN NOS CIL	V/

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY JONES

State Registrar

31. Date filed (Month, Day, Year) NOV 1 2 2008



To the Hospital of within 24 hours at To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** November David W. Morrison 6 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 01/26/1953 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1X M 2∏ E Director 137-40-8674 55 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Modical Examinate to notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1X Yes 2 □ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 Water Fountain Way, Apt. 203 21060 U.S.A. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Salesman Marine Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Morrison June Lloyd ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Morrison/Spouse 116 Water Fountain Way, #203, Glen Burnie, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 11/12/2008 Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Faneral Service Livensee 7522 Connelley Drive, SteP, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 40 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 3 Probably 4 ☐ Unknown Be Completed 2∏ No certificate has b irector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 □ No 2 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 ☐ Yes 2No Certification: To Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident s after dea... 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only

within 2 To the I

3

State Registrar

29b. Signature and title of certifier

30. Name and address of

Date filed (Month, Day,

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mo

32. Degistrar's Signature

rson who completed cause of death (Item 23a) (Type, Print)

				Please	State of M				. Ensure A Health and N	•		_	
Pin				For State Registrar	Otate of Wi	ai yiaila i		tificate of		vieritai i i	Reg. No	2000	35798
2		Physicia	an	1. Decedent's Name (First, Middle, La	*					2. Date of D Month	Day		3. Time of Death
7	No.	/Medic		Joyce Helen 4a. Facility Name (If not institution, give				4h City Town o	r Location of Death	Novemb		2008 . County of Deat	4:03 P.M
	J. Committee	Examin	er	Gilchrist Hosp				Tows			101	Baltim	
80	F	uneral		Social Security Number 6. S		je (In yrs. last		If Under 1 Year Months Days		8. Date of Bi	rth ay, <i>Year)</i>		thplace (State or Foreign puntry)
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	yland	MOL T		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	e Mar	a-fst	ctor	Maryland Baltim	ore		Ва	ltinore					1 ☐ Yes 2 ∰ 1/40
,	/ith th	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit Ul'11	tizen of What Co ted Sta	untry? tes
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+	tter de	r Item	Fun	11. Marital Status 1 ☐ Never Married 2万 Married	Armed Forces?		13. 1	f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	0-	14. Race - Ame Black, White	rican Indian, e, etc.
A1115t	faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mantal Hydiene	ral", o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	∐Yes 2√⊡No	Specify:			Specify: [V]	hite
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7	Filed Hyd	other /ent, I	Be C	17. Father's Name (First, Middle, Last)		100	ACTICE	18. Mother's Nam	e (First, Middle			y_5C11001
	Vlar uld be	arked atic e	To E	Herman B. Goye	rt				Mati	lda Mey	er		
0)	Aar 2 sho	'is ma		19a. Informant's Name/Relationship (**			-	and Number or Ru				
2	1 and Healt	em 27		James Daniel McCa 20a. Method of Disposition	Ilister/ s			19 Hallhเ sition (Name of		Balti Date		, Maryla	and 21236
70	nor Pages ent of	y or o		1 ☐ Burial 2 ♣ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Evails	eter ciere	atory of other place	^{ce)} Nove	mber			l, Maryland
5	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte	Important: If tem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Examinat must be natified at once.		21. Signature of Funeral Service Lice		Char	Del-	Bel Air Name and Addre	ss of Facility	2008			
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				23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	d the death. I	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory	arrest,	1	Approximate Interval Between
		sician		Immediate Cause (Final disease or condition resulting in death)	a. MET.	ASTAT	TC 0	VARIAN	CANCE.	R			Onset and Death MONTHS
+		edical miner		resulting in death)	Due to (or as	a consequen	nce of):						
4694			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequen	ice of);						
于一	D, executed	nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
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#	687 tifficate	attending physician and for use as the burial-transit			_ d								
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3	. ö	he atte	sicia	in the past 12 months? 1 □Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown] Ectopic pregnand] Other <i>(specify)</i>	У			Month	Day Year
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3	dS, lires t	d be c	d by	Tartii. Other significant conditions	ontributing to death b	out not resultin	ig in the ur	idenying cause giv	en in Fait i.	i			robably 4 🗆 Unknown
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	ian:	ertifice ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of Dea			1 Li Yes	2 □No
	ohysk	this or	၉	1 Yes 2 No	-	ent 2□ER			4 LI Nursing H			6 Other (Spe	city) HUSPICE
	Division of Vital Records, I or Attending Physician: The law requires that edeath.	After	tion	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		Bb. Time of Injury	Wor	ryat k? Yes 2 □ No	28d. Describe	how injur	y occurred	
	VISI Atten r deat	ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	ury - At home	e, farm, stre	eet, factory, office	1163 2 1110				ural Route Number,
i	Div tal or	al Dire	Certification:	4 Homicide determined	building, et	tc. (Specify)				City or To	wn, State	•)	
	Divisio To the Hospital or Attendi within 24 hours after death.	To the Funeral Director: After this certificate ho completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best miner: On the basis of	of examination	edge, death n and/or inv	occurred at the ti	me, date and place opinion, death occu	, and due to the	e cause(s , date and) and manner as d place, and due	s stated. to the cause(s)
(0)	Fo the	Го the хотрк	Mec	29b. Signature and title of certifier	and manner st	aled.		29c. Licens	se number		29d. Dat	ite signed (Monti	h, Day, Year)
				100		1-		20	64395		NOVE	EMBER 1	1,2005
		2		30. Name and address of person who	completed cause of c	death (Item 23	Ba) (Type, I	Print)	- 41:30	100 0	4-	M mad & d	V0 223 201
			10	DANIEUE DREEDS 31. Date filed (Month, Day, Year)	32 Registr	rar's Signature	9		, sullE 2	07 01	14/11	WILE, N	2041204
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Jouglas Moats	State of Maryland / Department of Certificate of Ce			=1 0						
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	2.	Reg. No. Date of Death Month Day Vear Vovember 7, 2008 Reg. No. 3-Time of Death Year 0116 hrs	. 19						
*	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Vovember 7, 2008 OTTO TIS	-						
	Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore	N/A Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Funeral Director	214-74-8854 ₁ X _{M 2} F 50 _Y	Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD							
апу	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation	10d. Inside City	Limits						
Varyland 28a-f show any d at once.	MD N/A Baltimore		1 X Yes 2	No						
the Marylanc a or 28a-f sh tifted at onc	10e. Street and Number 2703 N. Howard Street	10f. Zip Code 21218	10g. Citizen of What Country?	U.S.A.						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? If	Vas Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- 14. Race - American Indian, Black	,						
fter dea	1 X Yes 2 No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1976–79	Yes 2 X No specify:	Specify: White							
hours aft natural" Examine	or Dates:	ent's Usual Occupation (Give kind of work	done 16b. Kind of Business/Industry							
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cons	Hame Improvement								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than r event, the Medica		rst, Middle, Maiden Surname)								
2121 tould be fill d Mental I is marked tic event,	Douglas English 19a. Informant's Name/Relationship (Type, Print) 19b. Maiili	Loretta Moa ng Address (Street and Number or Rura	TS Il Route Number, City or Town, State, Zip Code)							
MD nd 2 sho alth and 27 is raumati		N. Howard Street, Balt								
TOFE, ages 1 and of He It: If ite other to	1 X Burial 2 Cremation 3 Removal from State crematory or		20c. Location - City or Town, State /2008 Sykesville, Maryland							
Baltimore, permit. Pages I ar Department of Hee Important: If ite njury or other tr	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Leon	ard J. Ruck. Inc.							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
/Medical `xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately approxima									
Zailli i e i	or condition resulting in death) Due to (or as a consequence of):									
iner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause									
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760, ficate be g physici the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery							
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ires that the signed by be detach	Endstage liver disease with compl		1 Yes 2 No 3 Probably 4 Vunkr	nown						
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Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical	00.00		No						
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Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been si led in by the funeral director, page 2 should bertification: To Be Completed	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Month, Day, Year)	Injury 28c. Injury at Work? 28	d. Describe how injury occurred							
Division ospital or Attending rours after death. meral Director: Aft filled in by the func Gertification:	2 Accident Investigation 28e Place of Injury - At home, farm, str		f. Location (Street and Number or Rural Route Numbe	r, City						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Exa	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investig									
Ne present	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
	30. Name and address of person who completed chise of death (flem 23a)	O.C.M.E.	November 7, 2008							
0	Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimore, I	MD 21201							
State Registra	31. Date filed (Month, Day, Year) NOV 1 2, 2008	9)								
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [35800 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day November 6, 2008 **Physician** Alicia Meeks 1:27A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth Month, Day, Year) June 26, 1914 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Days 94 IN Director 317-20-2451 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tre Medical Exercitar must be notified at 1 ☐ Yes 2 🖾 No Director Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8419 Norwood Drive 21108 II.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fund Mental I James W. Clinton Agnes V. Hassett 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health au Important: If item 27 le eny injury or other trau 900ce. Mrs Mary Jo Coyner/Daughter 504 Red Bluff Court Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 12, 2008 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 □ Removal from State St.Ann's Catholic Cem. New Castle, IN * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral &21. Signature of Funeral Service Licensee MUV918 Services 1 2nd Avenue SW Glen Burnie, MD 21061 Hwalle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician agrapa disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 90 2 No 3 Probably 4 □Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate of Vital 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dispatient 2 ER/Outpatient 3 DOA his After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? Hospital or Attending 1 Nattural 5 Pending Stipped on Hoor after death. 3 1 ☐ Yes 2 ☑ No 2 Accident To the Within 24 hours.

To the Funeral Director. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ke sidence Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Jay, Year) 020094 Park Drive, Glen Purate, und, 2106/ who completed cause of death (Item 23a) (Type, Print) my Medish FllwH 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 Registrar

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			For State Of Marylan State Registrar		tificate of L		-	Reg. No.	71111	8 35801
Ť	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day		3. Time of Death
	/Medic	al-	Roy E Martin 4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death	Novem		Counfy of Dea	
7	Examin	er	Johns Hopkins Buynew Medical Cent	ex	Baltin				occini, or box	2011
3 -	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Bi	rthplace (State or Foreign ountry)
PHE .	Director		218-62-2037 53 Usual Residence of Decedent	Yrs.			FEB. 2	7, 1	955	MD
	yland how at			city, Town or Loc	cation					10d. Inside City Limits
	ne Mar Ba-f sl	Director		ARROWS						1X Yes 2 No
	with the	Dire	10e. Street and Number		10f. Zip Code			_	zen of What C	ountry?
	death ms 23 r mus	Funeral	2211 SPARROWS POINT RD. 11. Marital Status 12. Was Decedent Ever in Carried Forces?	U.S. 13. V	21219 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	USA	14. Race - Am Black, Wh	
220	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentell Hygiene. The stand Mentell Hygiene. The marked other than "natural" or Items 23a or 28a-f show them 27 is marked other than "natural" or Items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Specify:	r noun, cro.,		Specify: WI	·
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ני.	Health Health tem 27		SANDRA MARTIN 20a. Method of Disposition 20b.	Place of Dispos	SPARROWS sition (Name of		Date SPAI		cation - City o	
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Dale	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service Acensee		2007–09	ss of Facility WES	SLEY CHA	AVIS,	JR. F	NRL. HM.
	- 8		23a. Part I. Enter the disease or complications that caused the decisions, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	IORE, M	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition							Onset and Death
<i>y</i> .	/Medical Examiner		Due to (or as a conse	equence of):					-	
ij,	0/	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse							IWEEK
1	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
ç o	tificate be executed g physician and as the burial-transit	I Ex	resulting in death) Last Due to (or as a conse	equence of):						
700	icate b physic s the b	edical	d							
X	n certif		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy				23d. Date of d	elivery
	the deat y the atti iched for	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown		Other (specify)				Month	Day Year
Ľ	ss that gned b	by Pr	Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute	to the cause of death?
ecolds,	require een sig	ted					1 🗆	Yes 2	□ No 3 □ I	Probably 4 Unknown
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5	nding tth. r: After e fune	tion	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 □ No			,	
DIVISION OF	i or Atter after dea Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (City or To	Street an wn, State	d Number or i	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use it	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king the property of the passis of examinating and manner stated.							
	To the within To the comple	Mec	29b. Signature and title of certifier		29c. License	e number		29d. Dai	te signed (Mo	nth, Day, Year)
•	1		Keyan & Stogerono			-000		Nove	mber	7,2008
	6		30. Name and address of person who completed cause of death (ltd.			Ω.Δ. –			212	
	Sta	te.	Ryan E. Stago M.D. 4940 31. Date filed (Month, Day, Year) 3. Registrar's Sig	nature	RN AVENI	ut 10HL	I MOKE,	IV(D	212	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John B. Morrow November 2008 2:13 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 21, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M M 2 □ F Dec. 1930 Oklahoma Director 466-40-2998 77 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if the Medical Examinar must be notified. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYes 21X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Nicholson Lane, #801 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1⊠Yes 2□No If Yes, Give Year or Dates:Korea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 _ } 1 ☐Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) Marketing Manager Business Machines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ John Thomas Morrow Jessie Faye Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn M. Logan/Daughter 1090 Pipestem Place, Rockville, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. Nov. 12, 2008 | Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Butten 14cm M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Stroke 48-72 hours /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction 48-72 hours Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Still to for as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Acute Renal Failure 48-72 hours and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical Rhabdomyolysis 48-72 hours 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cirrhosis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a. Was an autopsy performed 2 □ No 1 ☐ Yes 2 ☑ No 1 ☐ Yes this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural n 24 hours after death. e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pompletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D67486 November 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Li, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Yuneng 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 1 2 Registrar

Please 7

Type or Print in Black Indelible Ink. Ensure All Co		
State of Maryland / Department of Health and Menta	al Hygiene 2008	35803
Certificate of Death	Pog No	

Physician
/Medical
Examiner

For State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Exprise must be notified at agree. Once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar					lilicate of	Dealli		He	g. No.		
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ner	4a. Facility Name (/					4b. City, Town, o		of Death		4c. County		
	24 Cour		Square,		l 4 l - 1 - 4 l - 1 - 1 . 1	Rockvi If Under 1 Year	TTE TIf Under	- 24 Hrs 1 (3. Date of Birth	riont	gomer	place (State or Foreign
			6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	iasτ birτnday) Yrs.	Months Days	Hours	Min.	(Month, Day,	Year)	Cou	ntrv)
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120	10e. Street and Nur	nber				10f. Zip Code			10	g. Citizen of	What Cou	ntry?
<u>a</u>	24 Cour	thouse	Square,	#302		20850			U	nited	State	es
Funeral Director	11. Marital Status		12. Was Dec Armed F	cedent Ever in U.	S. 13.	Was Decedent of H	lispanic Or an, Mexica	rigin? (Spec	eify Yes or No- ican, etc.)		ce - Ameri	can Indian, etc.
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B	17. Father's Name	(First, Middle,	Last)				18. Moth	er's Name	(First, Middle, N	laiden Surnai	me)	
ျ	Clement	L. Mc	Gowan, Jr	•			Mari	ie Mer	kling			
	19a. Informant's Na	ame/Relations	ship (Type. Print)		19b. Mailii	ng Address (Street	and Numb	per or Rural	Route Number,	City or Town	, State, Zi	p Code)
	Irene H	. Pora	da/Sister		146	l7 Rollin	ig Gre	een Wa	y, Nort	h Poto	mac,	MD 20878
	20a. Method of Dis	4	_	20b. F	Place of Dispo	osition (Name of matory or other pla	ce)	Da		0c. Location	- City or T	own, State
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×	Part II. Other signi	ficant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part	l.	23e. Did tob	acco use cor	ntribute to	the cause of death?
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tate		NOV I 2		Carre 1	C. A	and i						

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stephen McNeill November 8 2008 2:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2864 Potee Street Brooklyn Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number Sex 124 M 2□ F 7. Age (In yrs. last birthday) **Funeral** Hours Days 59 Yrs 240-84-4267 AUG 27, 1949 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director MD Anne Arundel Brooklyn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ö 2864 Potee Street 21225 USA 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No ò Specify: Specify: Black à 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) filed withir Hygiene. Operator 1 contract 1 Chemical Company 12 should be filed with and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk Marie Crowmatie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Betty McNeill/Wife 2864 Potee Street Brooklyn, MD 21225 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If iter any Injury or ott 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/10/08 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final UNO 200 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a year ling to make cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Exami burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Ö cate has been signed by the page 2 should be detached 9 Unknown Ū, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 ☐ Yes 2 ☐ No 2. No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending death. 1 ☐ Yes 2 ☐ No s after death.

I Director: A id in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) 2016 State 2008 1 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death MCDONOU6H **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE ARBOR CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day, 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Months 1 M 2 M New Jerse Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City I imits 10b. County a or 28a-f show t be notified at 28a-f show 1 Ves 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Monroe item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ ivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) if Health and Mental Hygiene. College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
Maxine Merniam 17. Father's Name (First, Middle, Last) Be ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monroe Circle 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Cremotor 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 10/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. CARDIOVASCULAR DISEASE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed wher death. Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 1∐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours ofter death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyer stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif

State Registrar

DHMH 17 Rev 1/2001

NILANTHA
31. Date filed (Month, Day, Year)

NOV 1 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CENORA , MD

32. Pogistrar's Signature

Sport

D 00 63941

BOOI S. HANDVER STREET, BALTIMORE, MD 21225

NOVEMBER 6th, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 35806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Dwayne A. Nicodemus 06:50 PM NOV 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPIT BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 214-48-4162 Months Days Hours Min. Director Aug.1, 1961 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the the discrete must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 506 Durango Road 21228 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" or item any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married 1 ☐ Yes 2 K No White Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Non Profit College (1-4or 5+) Elementary/Secondary (0-12) Athletic Director Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Nicodemus Mary Rice ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Nicodemus Wife 506 Durango Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBuria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 11/12/2008 Sykesville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 01490 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meta Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner y physician and is the burial-transit Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Day Year 5 Other (specify) 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? this certificate 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director; 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Propatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of

30. Name and address

31. Date flied (Month, Day, Year)

Records,

Division of Vital

VICEDEDIC

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

900 Caton

MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death 2008 Month Day **Physician** 8 40 am Joyce C. Norris Vovember /Medical 4c. County of Death me (If not institution, give street and number 4b. City, Town, or Location of Death Examiner fear | If Under 24 Hrs. | Min. a 8. Date of Birth (Month, Day, 2 / 18 / Under 1 Year Birthplace (State or Foreign Country) Funeral Number 7. Age (In yrs. last birthday) 1 □ M 2 🗹 F Months Days Hours Yrs Director 214-30-4373 73 18/1935 West Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Medical Examinating units of 1 ☐ Yes 2 No Director Baltimore n/a MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4411 Hillside Avenue 21229 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ▼ No
If Yes, Give Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify. <u>≨</u> White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F is marked ott Howard Shaffer Cleo Osburn 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health an
Important: If item 27 is
any Injury or other trau Richard R. Norris/ Husband 4411 Hillside Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 11/13/2008 Baltimore, Maryland 22. Name and Address of Facility
Hubbard Funeral Home, 21. Signature of Funeral Service Licensee Inc. mauit. Baltimore, MD 21229 4107 Wilkens Avenue or semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, iet only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) 10min /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continuation. burial-transit attending physician and Due to (or as a consequence of): NCVVIS JUNCと Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 **1**0 cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nore mp 21229 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan	-	artmen rtificate			and M	lental Hygi	ene 0	8 35	808
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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(\$		30. Name end address of person	·								THE R. P. LEWIS CO., LANSING, MICH.	
		10	Dr. John G. 31. Date filed (Month, Day, Yea	LOGMELL 2901	Olne strar's Signa	y-Sandy	Spring	Rd Olne	y, MD 208	332			
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	3a or 2	I Dir	10e. Street and Number 16 MAINVIEW COURT			10f. Zip Code	21133	10	g. Citizen of What C	country? JSA
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Baltimore, Maryland	Pages ment of ant: If it ury or o		1 🕅 Buriat 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	yat from State cen	OHEB S	HAL PARK	ee)		REISTERST	,
Balt	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any injury or other tra once.		21. Sign three Funeral Service line	uger	22. 1	Name and Addres	ss of Facility SO	L LEVINS	ON & BROS	5., INC.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	e on each line.	Do not enter	the mode of dyin				Approximate Interval Between
dan.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent	nemo	712				Onset and Death
	Examiner		Sequentially list conditions, b	Due to (or as a consequer	nice or,.					·
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):					
Ö,	tificate be executed g physician and as the burial-transit		that initiated events c c	Due to (or as a consequen	nce of):					
68760,	fficate t g physic is the b	edical	d							
O. Box	The law requires that the death certific tee has been signed by the attending page 2 should be detached for use as to	Physician/M	in the past 12 months?	yes, outcome of pregnand Live birth 2 Pretal de Pregnant at time of dea	eath 3 🗆 E	Ectopic pregnancy Other (specify)	У		23d. Date of d	elivery Day Year
S, D.	signed by	by	Part II. Other significant conditions contribu	ting to death but not resulting to Dement?	Ü	erlying cause give	en in Part I.		/	to the cause of death?
Records,	w requir s been s should	leted		Dear 11/12				1 ∐ Yes 24a. Was an		Probably 4 Unknown
		Completed						autopsy performe	prior to death?	completion of cause of
Vital	ysician; The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospi	tal:		Othe	26. Place of Death	(Check only one)		
Division of	Attending Physician; ir death. ector: After this certific by the funeral director,	on: To	1 100 2 110	I I Inpatient 2 I EF	8b. Time of Injury	3 ☐ DOA 28c. Injury Work	4 Nursing Hor	ne 5 Resident 28d. Describe how	ce 6 ☐ Other (Sp injury occurred	ecify)
SIO	Attendir death. ctor; A. y the fu	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	Be. Place of Injury - At home		M 1□	Yes 2 □No	nos I acatica (o)		
Ω	tal or A s after al Direct	Sertif	4 ☐ Homicide determined	building, etc. (Specify)	e, iailii, silee	i, lactory, office		City or Town,	et and Number or F State)	dural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examinatio and manner stated.	edge, death on and/or inve	occurred at the tir stigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner a e and place, and du	as stated. e to the cause(s)
	Vithi Vithi Comp	ž	29b. Signature and title of certifier	Ben		29c. License	_		I. Date signed (Mon	
	10		20. Name and address of person who comple	tod aguae of dooth (Item C	3a) (Type, Pri	(m#1)	0059943		vovember	
	10		John C. AbelMO	2-15 Stoney 32. Registrar's Signatur	1	· Suite	-307 W	restminis	R NO	-21157
	Star Registra		31. Date filed (Month, Day, Year) NOV 1 2 2008	2. Hegistrar's Signatur	e Alan	So P				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

3. Time of Death

10d. Inside City Limits

white

1 ☐ Yes 2√2 No

unk

20721

Approximate Interval Between Onset and Death

Dav

29d. Date signed (Month, Day, Year)

Year

6:00 AM

Physician /Medical Examiner

1 - For State Registral

Funeral Director

the Maryland ral", or items 23a or 28a-f show Examiner must be notified at Director Funeral Completed by Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netur any Injury or other treumatic event, the Medical ith and Mental h Be ပ

timore, Maryland 21215-0036

Pages '

Physician /Medical Examiner

Examiner burlal-transit attending physician for use as the burla Physician/Medical the detached certificate has been signed by rector, page 2 should be detacl δ Completed To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be Certification: To

Attending Physicien: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year John Sydney Fawcett Newnham 31,2008 Detober 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F Months Days 212-60-0716 83 Aug 4, 1925 United Kingdom Usual Residence of Decedent 10a. State 10c. City. Town or Location MD Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road #258 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 computer analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Fawcett Newnham Mildred Gertrude Sellers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Newnham/spouse 10450 Lottsford Road #258 Mitchellville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation _5 ☐ Other (Specify) 21. Signature of Emeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failur. List only one cause on each line. Immediate Cause (Final NEUMONIA disease or condition resulting in death) Due to (or as a consequence of): SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural
Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who com-

31. Date filed (Month, Day, Year) 1 NOV 1 2 2008

D. George

oted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MDD58182

MD. 7500 Hangver Parkway Suik 101A, Greenbeit, mD. 20170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 58 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Mard 12:15 PM 09 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Har box Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code Funeral Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Mar#ed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 77 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver 17. Faner's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Surname) Be 2 Route Number, City or Town, State, Zip Code Important: If item 27 is any injury or other traun Shel daug hiter 1 d bank 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition **B**urial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 5 ton disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Ente Immediate Cause (Final disease or condition resulting in death) Intarction **Physician** Muncardial /Medical Duevo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ş 4 ☑ Onknown 3 ☐ Probably Hypertension 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Polycythemia funeral director, page 2: autopsy performed? certificate 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOD November, 09, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Hanover St Baltimore, Hamad asis

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - State of Marylan		artment of Hortificate of L		lental Hygie Reg.	2000	35813
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Plubeth Ann O'Donn	ell			2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 7 01d Forge Cowt		4b. City, Town, or Spark	<u>s.</u>		4c. County of Death Baltim	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2XF 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 9-25-3	ar) 9. Birtl	nplace (State or Foreign untry)
	e Maryland Be-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. Ci MD Ballmore		10d. Inside City Limits 1 ☐ Yes 2 XÎNo				
	th with the 23a or 2 and be no	ai Dire	10e. Street and Number 1 Old Forge Court		10f. Zip Code 2115:	2.	10g.	Citizen of What Co	untry?
920	hours after death with the Maryland turel; or Items 23a or 28e-f show at Exertirer rust be notified at	by Funerai	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	d within 72 jiene. r than "nel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired) HOUSE WI	tion uring most of work	ing	Kind of Business/I	,
Maryland 2	be file tal Hyg id othe svent,	To Be C	17. Father's Name (First, Middle, Last) Mark J. Gugerty			18. Mother's Name	7 7 7 7	hus.	
-	s 1 and 2 of Health a item 27 is		19a. Informant's Name/Relationship (Type, Print) ROSANT S. D'OMAKK (1987) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	7 04	ng Address (Street all Company) In the street of the stre	CT. 4	al Route Number, Cit	ty or Town, State, 2 21152, Location - City or	
Baltimore	permit. Pages Department of I Important: If it eny injury or o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	HI	Name and Address	JENKINS	7/2008 To	co.	n m.
A MANAGE	Priysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a line of Sequentially list conditions,	th. Do not end	5924 YOR er the mode of dying	K RD MO	NKTON , MT or respiratory arrest,). 21111	Approximate Interval Between Onset and Death
- '09/80	tificate ba exacutad ng physician and as the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect cause) C						
C. BOX	death cer e attendir id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 1 1 1 2 ☐ Fett 4 ☐ Pregnant at time of constant at time	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of deliment	very Day Year
rds, P	The law raquires that the de ste has been signad by the a page 2 should be detached f	by	Part II. Other significant conditions contributing to death but not res		tobacco use contribute to the cause of death? Pes 2 No 3 Probably 4 Unknown				
Vital Records,		e Compieted	25. Was case referred to medical				24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
o	Attending Physicien: rr death. ector: After this certifici by the funeral director,	ToB	examiner?	ER/Outpatier 28b. Time of Injury	t 3 DOA Other	4 Nursing Ho	6 ☐ Other (Specify) jury occurred		
DIVISION	ir te	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specification)	(y)			28f. Location (Street City or Town, St	ate)	
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my known one) Medical Examiner: On the basis of examination and manner stated.	wledge, death	n occurred at the time restigation, in my opi	e, date and place, a nion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	V Vith	2	29b. Signature and Atle of certifler Cambo	P	29c. 13245 D345	nymber 521		Date signed (Month	
_	le		30. Name and address of person who completed cause of death (Iter Mark Allan Lamos 9 Schill			nt Valle	y, Md. 210	031	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature	2.00				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2044 M STANLEY ORING 2000 Novembre /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Bultimore /timon 8. Date of Birth (Month, Day, Year) 04/22/1922 6. Sex 1 🔀 M 2 🗆 F If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 156-01-0913 86 NY Usual Residence of Decedent 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modest Exacting to context traumatic event, its Modest Exacting to other traumatic event, its Modest Exacting to other traumatic event, its Modest Exacting to other traumatic event, its Modest Exacting to other traumatic event, its Modest Exacting to other traumatic event, its Modest Exacting to other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE, APT. 507 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕅 Married 21215-0036 1 ☐Yes 2 💢 No Specify. WHITE ğ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) DENTIST DENTAL Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည HERMAN ORING anna BERNSTEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYRA ORING / WIFE 11 SLADE AVENUE, APT. 507, BALTIMORE, MD 20b. Place of Disposition (Name of central of product of the FALL) HE EMUNAH ALTZ CHAIM 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 11/11/2008 5 ☐ Other (Specify) 4 Donation BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatura of Juneral Service Licen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Inter the disease, or complication of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cardiecomes and line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician day disease or condition resulting in death) wiration /Medical Due to (or as a consequence of) Examiner 3-4 Jays lau Sequentially list conditions, if any, leading to fininediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician are the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use centribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No certificate Covanary 2 🖸 No 1 ☐ Yes filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident 1 □Yes 2 □ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours after death To the Funeral Director: completely

Patrient

State Registrar (Check only one)

29b. Signature and title of cortifier

ohn

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

29c. License number

mai Hospita

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Balakier Olczak 7:50 PM 08 /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner VA medical Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min. Sept18,1919 1 □ M 2 🛛 F 89 Maryland 213-03-1732 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Md. Baltimore Dundalk 1 □Yes 2XINo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 1204 Hillshire Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 DXYes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Clerical Fort Holabird 12 should be filed w h and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Balakier Josephine Krolicke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mit. Pages 1 and 2 s' oartment of Health an sortant: If item 27 Is ! / injury or other trau Georgia Famolaro(daughter)|1204 Hillshire Road Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Bayview Crematory 11-12-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Zolle 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Nephritis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: Se If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? Month Vear Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown cate has been signed by page 2 should be detack Part II. **O**the<mark>r significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 □ No 3 Probably 4 HUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? certificate 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No tospital or Attendi 4 hours after death. Funeral Director: A death. investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signate

State Registrar

10 N. Greene Street, Baltimore, MD Wilkinson, M.D. 32. Registrar's Şignature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

19010

11/08/

2008

		For 1 _ State	State of Marylan		rtment of F tificate of			$=$ $2 \cap \cap \Omega$	35816
		Registrar 1. Decedent's Name (First, Middle, Las	st)	Cer	lilicate of	Dealli	2. Date of Death	. No. 4 U U O	3. Time of Death
Physicia /Medic		Sundae 1	- Powell				Month	7 08	11:35 PM
Examin	200	4a. Facility Name (If not institution, give GOOD SAMARIT)				r Location of Death		4c. County of Death	1
Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	iplace (State or Foreign
Director		~19· JK: 17 17	^{□ M} ¾ 3√ 59	Yrs.	Months Days	Hours Min.	(Month, Day, Y		intry) MD
land ow ft		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mary a-f sho ified a	ctor	MD	N/A B	altim	ore				1X Yes 2 □ No
filed within 72 hours after death with the Maryland filed within 72 hours after death with than "natural", or items 23a or 28a-f show brit, the Medical Examiner must be notified at	Director	10e. Street and Number 945 Northhill	l Road		10f. Zip Code	218	10g	Citizen of What Cou	intry?
ns 238 must	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. \		lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Amer	
after o		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		t Yes, specity Cub I∐ Yes 2√∑xNo	an, Mexican, Puerto i Specify:	Hican, etc.)	Black, White	e, etc. Lack
"natural",	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Ed	Year or Dates:	16a. Deced	ient's Usual Occup	pation	16	b. Kind of Business/I	
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lled wii Hygien her th nt, the		12th grade	N/A	Bus	Operato	18. Mother's Name	/First Middle Ma	iden Surname)	
ld be fi ental h ked ot c ever	To Be	Norman Barlow	,			Dorothy		den damame)	
s 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me	-:	19a. Informant's Name/Relationship (Type. Print)		•			City or Town, State, Z	•
t and the the tree tr		Tara Wilson-Da 20a. Method of Disposition			7 Heath			c. Location - City or	
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permit. Departimporti		21. Signature of Funeral Service Licer	nsee		Name and Addre	· Pi	arch Ea	=	21202
make a		23a. Part1. Enter the disease, or conshock, or heart failure. List only	lications that caused the deat		-			Balto, MI	21202 Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a conseq PULMONA		YECRTI	NSION			
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	aldeath 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
that the		9 ☐ Unknown Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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To the company of the	ž	29b. Signature and title of certifier	Catila	M.D.	29c. Licens	se number	290	d. Date signed (Month	
H		30. Name and address of person who KHALED CHATI	completed cause of death (Iter	n 23a) (Type, LQCH	Print) RAVEU	RLVO	BALTZ	MORE, A	10,21239
Sta		31. Date filed (Month, Day, Year)	LA 5601 32. Registrar's Signa	ature	R		,		
Registr		NOV 1 2 2008		4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Year James Ε. Palmes November 10:04 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F 228-52-8321 Director 67 Aug. 12 1941 OH Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Extr. in the Department one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2323 Belair Drive Completed by Funeral 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telecommunications Specialist Dept. of Agriculture 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) C. ဥ Jack Palmes Jane Heaston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Belle Palmes (spouse) 2323 Belair Drive, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2008 Baltimore, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspengillos Physician disease or condition resulting in death) Preumania /Medical Due to (or as a consequence of): Examiner 1mm uno compini Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Dulmonary attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DUMBNAY 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has I funeral director, page 2 s 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu

Registrar

Medical

31. Date filed (Month, Day, Year) State

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

6 ☐ Could not be

D 500 07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atha

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6701 N.Charles St, Baltimore Md 2120

			1 – For State Registrar	State of Maryland		artment of H			ene g. No. 200	8 35818
П	Dhysisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
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<u>a</u>		ToE	Lawrence Be	ck			Eva	Gill		
ar\			19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailin	g Address (Street ar	nd Number or Rura	Il Route Number, (City or Town. State	. Zip Code)
Σ	1 and 2 Health a em 27 is ther tra		Lois Polaski (d	daughter)		Queen Ann				
Ze	S T H O		20a. Method of Disposition	20b. Pla	ce of Dispos	ition (Name of atory or other place	D	ate 20	c. Location - City of	
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens			Name and Address	of English			-
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5	Direction of	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,,	.,, a		City or Town, S	state)	urar noute Number,
	pspir hour mera y fille		29a, Certifier 1 Certifying Phys	sician: To the best of my knowle	edge, death	occurred at the time	, date and place, a	nd due to the cau	se(s) and manner a	as stated
	or the hospital of Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	n and/or inve	estigation, in my opir	nion, death occurre	d at the time, date	and place, and du	e to the cause(s)
F	Voith Com	Ē	29b. Signature and title of certifier			29c. License n	number	29d.	Date signed (Mon	th, Day, Year)
			ann A Hoston	10		1559	15	1	1-8-08	
	N		30. Name and address of person who co	mpleted cause of death (Item 23	3a) (Type, Pr	int)	/		0 3	
	9		Ann Marie Heste	(MD : 301 H	soi da		alen Bu	nie mo		
	State		31. Date filed (Month, Day, Year)	32. Registrar's Signature	9 /				····	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Day O (Year 08 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month | **Physician** 10:10 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner timore (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 X M 2 □ F 57 Yrs Director NOV. 28 1950 VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1K Yes 2 □ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 721 W SARATOGA STREET 21201 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify Specify: BLACK 3 Widowed 4 Divorced "natural" er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. tem 27 is marked other than CONSTRUCTION llth grade WMS CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ STERLING PAIGE JOSEPHINE PAIGE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Anna M. Paige/ Wife Saratoga St., Baltimore, Maryland 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurjal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) WOODLAWN CEMETERY 11-13-08 BALTIMORE, MARYLAND Swatture of Funeral Service Licenses 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE nu Part 1. Enter the disease, or c shock, or heart failure. List of Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. nly one call mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 ✓ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. within 24 hours after death

To the Funeral Director:
completely filled in by the t filled in by

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital 0

Koren Jenkins 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 0067660

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

827 Linden

2

32. Registrar's Signature

_		ı	For State Registrar	State	e of Ma	ıryland		rtment of F		Mental Hy	/giene / Reg. No.	2008	35	820	
	Physicia	an	1. Decedent's Name (First, Mid	dle, Last)						Date of Demonstration Month	eath Day	Year	3. Time o		
1	/Medic			.ce Parker						11	09	2008	6:20	а м ———	
	Examin	er	4a. Facility Name (If not instituti		nd number)			4b. City, Town, or		ath	4c. C	ounty of Death			
VIII			Joseph Richey F 5. Social Security Number	lospice 6. Sex	7 Age	(In yrs. las	t hirthday)	Baltim If Under 1 Year		s. 8. Date of Bi	rth	9 Rirth	nlace (State	or Foreign	
	Funeral Director		217–58–9002	1 M 2 M			Yrs.	Months Days	Hours Mir	1. (Month, D		Maryla	ntry)	or Poreign	
			Usual Residence of Decedent			61	1			04/04/19)4/	12.27 20			
	yland		10a. State 10b. Count	ty		10c. City, 7	Town or Loc	cation							
	a-f sl	ctor	MD Baltimore										1A Yes 2 □ No		
	or 28	jre	10e. Street and Number					10f. Zip Code			10g. Citize	n of What Cou	ntry?		
	th wil	Funeral Director	600 N. Grantley	St.				21229			US	A			
	ems	nel	11. Marital Status	12. Was	Decedent E	ver in U.S.	13. V	Vas Decedent of H	ispanic Origin? (Specify Yes or N		Race - Ameri Black, White,			
36	or it		1 X Never Married 2 ☐ Ma	arried 1 🗆	Yes 2 📉 No s, Give or Dates:	0		□Yes 2 No	Specify:	,		Specify: Blac			
8	nours ural"	q p	3 Widowed 4 Divorce			-									
<u> </u>	"nat	Completed by	15. Decede (Specify only high		eted)		16a. Deced <i>Give </i> <i>lifa F</i>	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of we	orking	16b. Kind	of Business/In	dustry		
2	withir ene. than	m C	Elementary/Secondary (0-12) 5 years	Colle	ege (1-4or 5+	+)		e Keeper	1)		Mote1	Townhous	e		
9	filed Hygi other	ပိ	17. Father's Name (First, Middle	e, Last)				<u> </u>	18. Mother's Na	ame (First, Middle					
an	d be ental ked o	To Be	Raymond Whee	1er						n Parker			place (State or Foreign intry) 10d. Inside City Limits 11 Yes 2 No intry? can Indian, etc. 2k dustry e Approximate interval Between Object and Death Dably 4 Unknown posy findings available impletion of cause of 2 No find No No find No No find No No find No No find No fi		
ALCE PARKER WIRELUNGER HOOM BANK (1/91)で らるで Baltimore, Maryland 21215-0036 Attending Physician: The law requires that the death certificate be executed U.S. Box 68760, Box 6	shoul nd M mari	F	19a. Informant's Name/Relation)		19b. Mailin	g Address (Street			ber, City or 1	– Town. State. Zij	Code)		
. 8	nd 2 alth a alth a 27 is		Lisa D. Parker/					. Grantley			-		,		
re,	s 1 ar		20a. Method of Disposition			20b. Plac		sition (Name of natory or other place		Date		ation - City or To	wn, State		
ê	Page: ent o nt: If		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (from State		o Crema			1. 12000	Q - 1				
霊	+ E 2 4		21. Signature of Funeral Service			TELL	22	. Name and Addre	ss of Facility	4/2008	Catons	zille, MD			
ä	permi Depar Impor any Ir once.		Lumenla	Jone.	2		6.	38 N. Gilmo	w or St Ral	to MD 212	al Home	e P.A.			
			23a. Part 1. Enter the disease,	or complications t	hat caused t	the death.						1	Approxima	te	
	Physician /Medical		shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a lon-equ-nce of):												
E.	Examiner														
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a	consequer	nce of):								
0	oute nd ransit	Examiner	that initiated events	C											
N 0	cate be executed physician and the burial-transit	Ä	resulting in death) Last	Du	e to (or as a	consequer	nce of):								
376	ate b hysici he bu	dical		d											
6	ertific ing p	Med	IF FEMALE:				. 40					l		a M or Foreign City Limits 2 □ No Year death Vear death Available cause of	
Z = E	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 mounts? 1 ☐ Yes 2 ☐ No	1 🗀 I 4 🗆 I	s, outcome o Live birth 2 Pregnant at t Unknown	2 ☐ Fetal de	eath 3 🗆	Ectopic pregnanc Other (specify)	у		23	d. Date of deliv Month	-	Year	
	at the by the	چ	9 Unknown												
s,	es the	þ	Part II. Other significant condit	tions contributing	to death but	t not resultir	ng in the un	derlying cause give	en in Part I.						
- br	equir	<u>8</u>								. 10	Yes 2	No 3 Prol	oably 4 🗗	Unknown	
S S	law r as be	Completed								24a. Was		24b. Were auto	psy findings	available	
	The sate h	5								perf 1 □ Yes	ormed?	death? 1 ∐Yes	•		
3.K	cian: ertific sctor.	Be (25. Was case referred to medic examiner?						26. Place of De	eath (Check only	one)	/	11		
A CONTRACTOR OF THE PARTY OF TH	hysi this o		1□ Yes 2 No		1 🗌 Inpatien				4 Li Nursing	Home 5 ☐ Res	idence 6	Other (Specia	MADA	VICA	
	After a	Certification: To	27. Man p of Death 1 V atural 5 □ Pend		Date of Injury Month, Day,	y Year) 28	3b. Time of Injury	28c. Injur Worl		28d. Describe	how injury o	occurred	1117		
CE	ttendi death. tor: /	cati	2 Accident inves	tigation					Yes 2 □ No						
ZI	l or At after d Direct I in by	E	4 Homicide dete	200. F	Place of Injur ouilding, etc.	ry - At home (Specify)	e, farm, stre	et, factory, office			(Street and I wn, State)	Number or Rura	al Route Nur	nber,	
1	urs a														
BEA	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 ☑ Certify (Check only one) 2 ☐ Medica	I Examiner: On t	o the best of the basis of manner state	examination	edge, death n and/or inv	occurred at the tir restigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) a , date and p	nd manner as s lace, and due to	stated. the cause(s)	
	vithis To th	Me	29b. Signature and title of certifi	* Die	4	110)	29c. Licens	e number	0	29d. Date	signed (Month,	Day, Year)		
	•		1MW W	1 MM	W/	111		11/	100/2		_///	9/18			
	7		30. Name and address of perso	who completed	cause of dea	ath (Item 23	3a) (Type, F	phit) de se	11-	41	21/1	1/1	101	2111	
	- 21		31. Date filed (Month, Day, Year	10/1	32. Registrar	Signature	2/1/	VIOI	185	111 /	0474	1119	14	48	
	Stat Registra		1011	2/2008	A Section	But at		CHAS			, s - and				
	- 3.0		- MATT	# F000	C. N. Saldan	- 7	- 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:30PM フフタペリ NOYEMBER 6,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE GILCHRIST TOWSON PALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 X F 577-38-857 Director 1. CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic event, It would be a supported as injury or other traumatic events. MARYLAND Director HOWARD JESSUP 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9403 S.H SPRINGLUATER 20794 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No <u>Ş</u> Specify Specify: BLACK 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTORY 1ST BOND CLOTHING WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GILES NATHAN AMANDA SIMMS ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY JUNE HORNER (DAUGHTER) 10379 ECLIPSE WAY, COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State METRO CREMATORY 11-12-2008 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) of Funeral Service Licensee 22. Name and Address of Facility
505EPH H. BROLUN JR, FUNERAL HOME uar 2140 N. FULTON AVE, BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed P. B burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) P.O. ed by the a 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t page 2 sl autopsy certificate perform 2 □No Division of Vital 1 □ Yes 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending investigation Natural Accident after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Directory filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the To the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 555W. Towartown Blud/Boeford 2004 authore MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

ORIGINAL

Driver in Flor in2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** M. Price 12:10 AM ERnestine Nov 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Valley Drive Fort Washington MD If Under 1 Year If Under 24 Hrs. 8. Date of Bird Prince 406 Patomoc George 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 ☐ M 2 💢 F Months Hours Min. Yrs. Sept. 13, 1945 Director 220-42-9834 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Fort Washington 10e. Street and Number 10g. Citizen of What Country? USA Valley Dr. Ve 12. Was Decedent Ever in U.S. Armed Forces? 406 Patomoc Drive 20744 by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event. In Medical Examiner must 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assisted Living 8 Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALTA M. Hillary 2 Leamond M. Blue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra R. Rose Apt 301 1514 Eutaw Place Bultimore MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State Arbutus, Maryland Arbutus Memorial NOV 15 2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Service Ronald A. Grayson Fu 270 Fred Hitm Pass Balto, mg 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. incld Immediate Cause (Final Physician disease or condition resulting in death) Malignant Neoplasm; other specified sites /Medical Due to (or as a consequence of): Examiner wterme ADNEXA -UterINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month Day n signed by the an Id be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼No 24a. Was an autopsy performe 2**X** No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie, 11/10/08 466665 60. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 200 LALGO MD 20774 9200 BASII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			for State Registrar	State of Ma	-	artment of Hea <i>rtificate of Dea</i>			ene g. No. 2008	35823			
	Physicia	an	1. Decedent's Name (First, Middle, Last) Angela		Parlo			Date of Death Month	Day Year	3. Time of Death 7:42 P M			
	/Medio	al	4a. Facility Name (If not institution, give s	treet and number)	10110	4b. City, Town, or Loca		ovember	6, 2008 4c. County of Death				
-	LXaiiiii	CI	Greater Baltimore	Medical (Center	Towson			Baltimore				
	Funeral Director		210-42-3741	7. Age	(In yrs. last birthday) 96 Yrs.		Jnder 24 Hrs. 8 ours Min.	Date of Birth (Month, Day (Arch 5,	9. Birti (2) 912 Gi	nplace (State or Foreign untry) ^eece			
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits			
	a-f sh	ctor	Md. Baltimore	2	Towson					1 □Yes 2 🛛 No			
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co.	•			
	eath w	Funeral Director	1106 Cowpens Ave	Was Decedent E	ver in IIS 13 V	21286	nic Origin? (Speci	fy Yes or No-	Gree				
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ergin har must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Vas Decedent of Hispan f Yes, specify Cuban, Mo I □Yes 2X No Sp		can, etc.)	Black, White				
5-0	72 ho "natur	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	10	6b. Kind of Business/I	ndustry			
	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	Homem				Own Home				
pu	e filed al Hyg I other vent, I	BeC	17. Father's Name (First, Middle, Last)			18.	Mother's Name (/						
ylaı	ould by Ments arked	으		ge l akos			Garisa			Karantzis			
Mar	d 2 sh th and t7 Is m traum	١,	19a. Informant's Name/Relationship (<i>Typ</i> Mrs. Pauline Pantel			g Address <i>(Street and I</i> 008 Roxleig			•	ip Code)			
e,	s 1 an of Heal item 2 other		20a. Method of Disposition			sition (Name of natory or other place)	Date		0c. Location - City or	Town, State			
<u>=</u>	Page ment c ant: If ury or		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Greek Ort		11-10	0-08	Woodlawn,	Md.			
Baltimore, Maryland 21	permit. Depart Import any Inj		21. Signature of Furieral Service Ligense	1-		1050 Yor	k Rd. To	eral Hor owson, N					
			23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
E.	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	GI Bleed						Onset and Death			
	Examiner				consequence of):	Failure							
	⊽ .=	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury		consequence of):								
	ifficate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		ve Heart I	Failure							
68760,	e be e sician buria	al E		200 10 (01 00 0	33/133443/133								
		l edical		-10-01-090									
.O. Box	Attending Physician: The law requires that the death cert cload. etr death. etr death. After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use it.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year			
S, P	res that signed b		Part II. Other significant conditions con	tributing to death but	t not resulting in the ur	nderlying cause given in	Part I.	23e. Did toba	acco use contribute to				
ord	require een si nould t	ted	Anemia					1 🗆 Yes	s 2 □ No 3 □ Pr	obably 4 🛣 Unknown			
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within £4 hours after death. To the Funeral Director. After this certificate has been s completely filled in by the funeral director, page 2 should	Completed by						24a. Was an autopsy perform 1 □ Yes 2	prior to o ed? death?	topsy findings available completion of cause of 2 \(\square\$ No			
Ζ̈̈́	siclar s certif	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	nt 2 ☐¥ER/Outpatien		Place of Death (•		-12.1			
ם ר	ig Phy ter this neral d	Certification: To	27. Manner of Death	28a. Date of Injury (Month, Day)	y 28b. Time of				nce 6 Other (Spec v injury occurred	city)			
sior	tendin eath. or: Af the fur	catio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □Yes	2 □No						
Ξ	or At after d Direct I in by	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office	28	f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,			
	ospital hours uneral ly filled		29a. Certifier 1 Certifying Phys	ician: To the best o	f my knowledge, death	n occurred at the time, d	date and place, an	d due to the ca	use(s) and manner as	stated.			
	To the Hospital or within 24 hours afte To the Funeral Director to the Funeral	Medical	one)	and manner stat	ed.	vestigation, in my opinio							
	7 wit	~	29b. Signature apolitile of certifier	//A		29c. License nun	(2) / (2)	γ	d. Date signed (Montl	i, Day, Tear)			
	/	17	30. Name and address a person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)JENNI	SEVE ELLI	CH. W.D.	11/10	0			
)	1	6701 north (hark	S.St.	TONS	200,1	Md	91904				
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 20	32. Registra	r's Signature		•		,				
				Part Part State St	W 650 BAS	Maria A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	iviai yia		•	ate of		iu ivic	R	eg. No.	20	08	35824
	Physicia	200	1. Decedent's Name	e (First, Middle, La	st)						2	. Date of Deat Month	Day	_	Year	3. Time of Death 1:30 AM _M
	/Medic	al	Dorothy		Elizabet		P	ringle				Novemb			2008	1.50 AM
	Examin	er	4a. Facility Name (/	f not institution, giv Spring As			r Cant			r Location of E Sprin			t		of Death mery	
	Funeral		5. Social Security N	lumber 6. 5		7. Age (In yi		day) If Ur	nder 1 Year	If Under 24	Hrs. a	Date of Birth (Month, Day,		$\overline{}$	9. Birthpl Count	
	Director		336-07- Usual Residence of	1/23		98		5.				CL. II;	, 19		I11i	nois
/land	Mo to		10a. State	10b. County		10c.	City, Town	or Location							10	d. Inside City Limits
Mary	#s-f.sh	ż	MD	Montgo	omery		Silve	r Spr	ing							1 □Yes 2 X No
th the	or 28	Jirec	10e. Street and Nur	mber				10f.	Zip Code			1			hat Count	ry?
th wi	23a wet b	Funeral Director	13600 C	reekside	Dr.				20904				USA			
ar de	items	nue	11. Marital Status		12. Was Deced	ces?	U.S.	13. Was De If Yes,	ecedent of H specify Cuba	lispanic Origir an, Mexican, F	n? (Speci Puerto Ric	fy Yes or No- can, etc.)	1		- America , White, e	
irs aft	li, or	by F	1	ied 2☐ Married 4☐ Divorced	1 ∐Yes If Yes, Give Year or Da	e 1 ∐Yes 2≝No <i>Specify:</i>							Specify: Caucasian			
2 hou	atura ical E	ted	23.	15. Decedent's E	ducation		16a. E	Decedent's	Jsual Occup	eation	f warking				siness/Ind	ustry
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d be fi	ental k	Be C	17. Father's Name Freder	ick Winbe								'Neill	vialdel1 C	umame	·/	
should	s mark	P.	19a. Informant's N	ame/Relationship	Type. Print)		19b. I	Mailing Add	ress (Street	and Number	or Rural I	Route Number	r, City or	Town, S	State, Zip	Code)
and 2	n 27 is		Jean Sn	yder/Daug	hter						r. S:	ilver S				
les 1	if iten		20a. Method of Dis	position XCremation 3 D	Bemoval from S	20b	. Place of E cemetery,	Disposition (crematory	Name of or other plac			Nov 15			City or To	
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permit p	Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantinar must be notified at once.		21. Signature of Fu	meral Service Lice	nsee	4015	733					Funera Sprin				on Ser. 20910
			23a. Part 1. Enter t	the disease, or con	plications that ca	used the de										Approximate Interval Between
Ph	nysician		Immediate Cause disease or condition	(Final	5	eni	$l_i + y$									Onset and Death
	Medical xaminer		resulting in death)		Due to (d	or as a cons	equence of):								
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/ petr	_usit	Examiner	Sequentially list co if any, leading to in cause. Litter Unde Cause (Disease or that initiated events resulting in death)	erlying rinjury	Due to (t	or as a corrs	equence of	<i>j</i> .								
exect	n and ial-tra	Еха	that initiated events resulting in death)	s Last	C. Due to (d	or as a cons	equence of):								
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artifica	ing ph	Medical	IF FEMALE:										Т			
ath ce	attendir for use	ian/I	23b. Was deceden			irth 2 🗆 F	etal death		oic pregnanc	су			2	3d. Date Mor	e of delive	ry Day Year
be de	the a	Physician/	1 □ Yes 2 L 9 □ Unknown	₩No	4 ∐ Pregn 9 ☐ Unkno	ant at time o	of death	5 ∐ Othe	r (specify) _							
that t	detached		Part II. Other signi	ficant conditions	contributing to de	ath but not r	resulting in t	the underlyi	ng cause giv	en in Part I.		23e. Did to	bacco us	e contr	ibute to th	e cause of death?
orday, requires t	n sign uld be	d by										1 □ Y	es 2] No	3 ☐ Prob	ably 4 🔭 Unknown
W rec	is been si	Completed										24a. Was a		24b. V	Vere autor	osy findings available inpletion of cause of
The g	ate has page 2	lmo:										autops perform		d	eath?	2 No
ian:	certificate ector, pag	BeC	25. Was case referexaminer?	rred to medical								Check only or	ne)			
Physic	this o	ျ	1 ☐ Yes 2			npatient 2						e 5 ☐ Resid				Assisted
aling F	n. After this certificate h funeral director, page	ion:	27. Manner of Deal	5 Pending		h, Day, Year	28b. Ti	me or ury M	28c. Inju	ryat "k?]Yes 2 ∐ No		ld. Describe h	ow injury	occurre	ed	
Attend	ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	investigation	28e. Place	of Injury - A	t home, farr	-		ITES ZEIN	_	f. Location (S	treet and	Numbe	er or Rura	l Route Number,
	after I Dire	Certification:	4 Homicide	determined	buildir	ng, etc. (Spe	ecify)					City or Tow	n, State)			
Hospit	within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	1 Certifying P	miner: On the ba	asis of exam										
o the	vithin 2 o the omple	Mea	29b. Signature and	title of certifier	and manr	er stated.			29c. Licens	se number		2	29d. Date	signed	l (Month, I	Day, Year)
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	10		30. Name and add			e of death (tem 23a) (1	ype, Print)		1. A		> 41			IA- A	20722
	10		S.M.		7	1D	37	17	381	AVE	2 (ottag	e C	ity,	(117)	20125
	Sta Registr		31. Date filed (Mor	10V 1 2 2	008 32 R	egistrar's Si	gnature	Grant.	30					f.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Puenland Cecile 8120 P M November /Medical 2003 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayriaw Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 😿 F Director 84 045-18-3042 Oct 10, 1924 Connecticut Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2√ No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 Kelso Drive #D404 21221 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item Man Elementary/Secondary (0-12) College (1-4or 5+) 8 housewife own home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Clephas Denomme Regina Elizabeth Bonin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Poehland/spouse 8620 Kelso Drive #D404 Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature Conal Service Conal censee Wade State Anatomy Board 655 W. Baltimore Street rector 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Baltimore, MD 21201 Onset and Death Physician Respiratory Failvre disease or condition resulting in death) INDUT /Medical Due to (or as a consequence of Examiner Backeremia days Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for es a nonsecuence of: The law requires that the death certificate be executed TPN Venovs Catheter Indwelling physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy 1 ☐ Yes 2**X** No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient After this funeral dir Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 □Yes 2 □No in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Nevember 5, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M-D EASTERN AVENUE

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day,

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Year)

BALTIMORE MID

21224

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/32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Joseph Ritter 1:25 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore BURNIE Medical Center Washington ANNE ARUNDEZ GLEN 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Hours Days Min. 6/26/1923 **№** M 2 🗆 F 85 Maryland 216-16-3471 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f si Injury or other traumatic event, the Medical Examinar must be notified. Director MD Anne Arundel Linthicum Heights 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 N. Hammonds Ferry Road 21090 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, The Man Elementary/Secondary (0-12) College (1-4or 5+) 0 Carpenter City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Ritter ည Mary Bishop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ritter / Son 377 Dublin Drive, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ∦ Buria □ Dona 2 Cremation 3 Removal from State Gardens of Faith Cem. 11/11/2008 Rossville, Maryland on 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Entity the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 7 PAYS /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed dio voiscular do care certenoscharota-Due to lor as a consequence of) attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. ed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 23e. Did tobacco use contribute to the cause of death? þ Physician; The law requires has been si e 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed yelowono cytre Leerteemro 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy performed page Vital 2 □No 2 No 1 ☐ Yes : After this certification of funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) within 2 the

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed ca

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2008

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se of death (Item 23a) (Type, Print)

GUART 2

32. Registrar's Signature

29c. License number

buch

Hospital &n. Ste 302

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35827 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 2008 2:45 A M 08 Η. Ethel Reese 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Franklin Square.
5. Social Security Number Rosedale Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. December 24,1917 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) 218-03-5824 1 □ M 2 T F 90 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21222 USA 3137 Liberty Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 __No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 12 years years Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Haught Lansing Headley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Ridgely Road, Glen Burnie, Maryland 21061 Kathy Hagel Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow ridge Cemetery 11, 2008 Halethorpe, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee Man 7110 Sollers Point Road, Dundalk, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, ir complications that caused the death D shock, or heart failure. Ut only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ubaraChnoid disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the deade(s) and manner stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> > Drive, Kallimore, MD

29d. Date signed (Month. Dav. Year)

requires that the death certificate be executed Box 68760, P.O. I of Vital Records, Division

Examiner burial-tran and physician the as attending p for use as ed by the a sign**e**d b plnods cate has I page 2 s After this certificate To the Hospital or Attending Physician: director, funeral neral Director: A death. hours after completely

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, If a Medical Examiner must be notified at

Physician

/Medical

Examiner

Physician/Medical

ģ

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

Binh

31. Date filed (Month, Day Year

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

within 24 hours a

State Registrar

Juare

p s in who impleted cause of death (Item 23a) (Type, Print) 9000 Franklin

Registrar's Signature

		For State Registrar	State of Maryla	•	rtment of H tificate of L		nd Ivientai		ene . No.⊃∫	ากล	35	22
Obseria		1. Decedent's Name (First, Middle, La	st)				2. Date Mont		Day	Year	3. Time of	Death
Physic /Medi		Serina	Rouse				Nove	nber	6, 20	108	7:40	A M
Exami	ner	4a. Facility Name (If not institution, given	·		4b. City, Town, or	Location of	Death		4c. County			
		13013 Midsummer 1 5. Social Security Number 6.8		rs. last birthday)	Bowie	If Under 24	Hrs. 8 Date	of Birth			orge's	r Foreia
Funeral Director			1□ M 2 X 1F 39	Yrs.	Months Days		Min. Sep.	of Birth h, Day, Y	^(ear) 1969	New	place <i>(State o</i> ntry) Jersey	7
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evandinal rough be notified at	or	10a. State 10b. County		City, Town or Loc	cation						10d. Inside Cit 1∭Yes	
the N	Director	Maryland Prince 10e. Street and Number	George's B	owie	10f. Zip Code			100	. Citizen of \	What Cou	ntrv?	
with Sa or		13013 Midsummer	iana		20715				5A		, .	
be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origii n, Mexican, I	n? (Specify Yes Puerto Rican, etc		14. Rac	ce - Americk, White,	can Indian, etc.	
", or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 ∐Yes 2 XNo If Yes, Give Year or Dates:	1	□Yes 2∏No	Specify:			Specif	<i>y</i> : D	1 a a le	
hour Itural	pa	15. Decedent's E		16a, Deced	lent's Usual Occupa	ntion		16	b. Kind of B		lack	
in 72 n "ne n	Completed	(Specify only highest gra	ade completed)	(Give life. L	kind of work done d OO NOT use retired,	uring most o	f working				es Depa	artm
filed within Hygiene. wher than	E O	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+) 2	Human	Resource	Speci	alist				tation	
othe rent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, M			_		
nould be in Mental marked o	10 E	Leroy Williams				Betty	Mae Lo	tt				
d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship	Type. Print)	19b. Mailin	g Address (Street a	nd Number	or Rural Route N	lumber, C	City or Town,	State, Zij	p Code)	
alth a		Senora Williams/	Sister	169 4	th Avenue	e East	Orange	, NJ	07017			
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		20a. Method of Disposition	206		sition (Name of natory or other place		Date		c. Location -		own, State	
Page ment c nt: If ry or		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	at tomovar nom orate	Laken emorial	1011 L	1	/14/200	a n	wideo	nvil'	1 _A MT)	
artm ortal inju		21. Signature of Funeral Service Lice	. 111		. Name and Addres							
Depared Important any ire	ŀ	1 Ann	L _s		6000 Anna						ar mome	
Medical of executed as the build-transit as the build-transit	al Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metastatic Due to (or as a cons b. Metastases Due to (or as a cons c. Metastases Due to (or as a cons	to Brainequence of): to Brainequence of): to Bone	Ln							
Ine law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Who 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3 □	Ectopic pregnancy Other (specify)			_		ate of delive		'ear
signed be de	b F	Part II. Other significant conditions	ontributing to death but not r	resulting in the un	derlying cause give	n in Part I.					the cause of d	
w requires to been signer should be	ted	Anemia					-	1 L Yes	2 X] No	3 Proi	bably 4 ☐ L	nknowi
	Completed by			<u> </u>				Was an autopsy performe	d?	Were auto prior to co death? 1 Yes	opsy fin d ings a ompletion of ca 2 No	available ause <i>o</i> f
rnysician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11 %-1		Law		f Death (Check o					
this o	ဥ	1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2			4 LI Nuis	ing Home 5 🖔		_		ify)	
er death. ector: After by the funera	o	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work			ribe how	injury occuri	red		
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in by	Certification:	4 Homicide determined		r nome, tarm, stre ecity)	eet, factory, office			ion (Stre or Town, S		er or Rur	al Route Numi	ber,
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To the nospinal or Attentining Physician. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		nysician: To the best of my k niner: On the basis of exam and manner stated.									
vithin To the	Me	29b. Signature and title of certifier	10		29c. License	number		29d	. Date signe	d (Month,	Day, Year)	
> - 0		Kum A	(lane	10 11 13	DI	122	1/		11/2	1/2-	200	
.10		30. Name and address of person who	completed cause of death (I	tem 23a) /Time 1	Print)	JU	/ /		11/6	, pc	08	
10		Rupa A. Varma,			Lane La:	rgo. M	m 20774		·			
Ct.	ete.	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	-0	-60, 11						
Sta Regist		NOV 1 2 200	Co.	Inature Aco	Es.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day North. Physician 12:40 AM ansom 6 /Medical not institution, give s Examiner Baltimore atonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 07-17yrs. last birthday) **Funeral** 1 □ M 2 X F 215-10 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exambor must be redified at Yes 2□No Baltimore Funeral Director 10g. Citizen of What Country? 201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 **X**No Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Tipe, DO NOT use retired) College (1-4or 5+) Father's Name (First Middle, Last, Be ဂ္ 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) portant: If item 27 y injury or other to Method of Disposition

1 ■ Burial 2 □ Cremation Pages 1 jo 3 ☐ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 23a. Part1. Enter tile isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt illure. List only one cause on each line. Immediate Cause (Final ARTERY **Physician** PISEASE ORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTENSIVE 1 ☐ Yes 2 No 3 Probably 4 Unknown CARDIOVASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **S**No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-2008

Registrar

3altimore.

P.O. Box 68760.

Records.

BUSINESS

32. Registrar's Signature

CENTER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UMA Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 8, 2008 **Physician** Donna Ruth 11:53 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 9505 Kingscroft Terrace Unit P Perry Hall 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F 74 6/10/1934 234-52-5259 WV Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c, City, Town or Location show ral", or items 23a or 28a-f shov Exs.nir er must be rofffled at MD Baltimore Perry Hall 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or in yor other traumatic event, the Modical Extention must be or 21128 USA 9505 Kingscroft Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shaver Noel Mary Cutlip မ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Taylor / Daughter 2453 Crystal Road, Hartly, DE 19953 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages
Department of I
Important: If its
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Cremation Serv. 11/10/2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** punccent in cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or injury that initiated events resulting in death) Last Examine Due to (or as e consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the innertal director, page 2 should be detached for use as the burial-transit Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No t**vo**ves 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D40854 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore 21202 227 S+ Paul Play ur, d MD Registrar's Signature 31. Date filed (Month, Day, Year) 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death November 8, **Physician** 2008 Roland Lee Robertson 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Maryland General Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□F 61 216-52-4085 April 12, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event than "had 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 North Curley Street 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Viote Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces?

1 XI Yes 2 No Vietnam
If Yes, Give
Year or Dates: US Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo ģ Specify: White 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Import-Export Warehouse Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Norman Η. Robertson Ι. Phannakuchen ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Robertson / Son Starwood Court, Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Ardent Cremation Serv. 11/11/2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 W. Warsha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Diffuse Intracranial Hemorrhage /Medical Due to (or as a consequence of):
Acute Renal Failure **Examiner** Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2**X**X\0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records. P.O. Box 68760. Director: within 24 hours at To the Funeral D completely

6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 89578 November 8, 2008

State Registrar

Medical

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2008

Saad Hagras

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DHMH 17 Rev 1/2001

Maryland General Hospital, Baltimore, MD

Amend #7,10e,perFH G885 11/12/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician XO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL BALTIMORE SEASONS HOSPICE @ RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/10/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛣 77-80 Director 215-28-8553 MD Usual Residence of Decedent death with the Maryland works) 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE RANDALLSTOWN r 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3808 KILBURN ROAD 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SOCIAL SECURITY than ' Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY ADMINISTRATION 2 should be filed w h and Mental Hygien is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT KARLOFF ANNA GLICK ပ Department of Health and Important: If item 27 is ma any injury or other trauma once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT RUBIN / HUSBAND 3803 KILBURN ROAD, RANDALLSTOWN, MD 20b. Place of Disposition (Name of complety, cramatery or other place)
CHIZUR AMUNO CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 11/09/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed ending physician and use as the burial-transi Exami Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year signed by the a I be detached fo 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 s certificate has autopsy performe 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation hours after death. uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 0 To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** NOVEMBER 9 2008 ANITA ROTH 14:53 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/19/1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Months Days Hours 77 216-28-1544 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or than "natural", or items 23a or 28a-f show the Woolcal Examinating the state of 1 X Yes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2903 FALLSTAFF ROAD, APT. 601 21209 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 No WHITE If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be. MAURICE GOLDSTONE SHAPIRO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
D: partment of Health au
Important: If item 27 is
any Injury or other trau JILL DAVIS / DAUGHTER 7 HARROD COURT, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State TIFERETH ISRAEL 11/11/2008 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 who Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Immediate Cause (Final **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-tran and physician a Box 68760, certificate be Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 5d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month 3 🗀 Ectopic pregnancy Day Year 5 ☐ Other (specify) _ signed by the a 9 Unknown Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Division of Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of fnjury After t 28d. Describe how injury occurred or Attending To the Hospital or Autorities within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending NOV 6,2008 3:00 PM 1 ☐Yes 2 No down tall investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 7 City or Town, State) 7 Harrod Court, Reisterstown, MD 28e. Place o Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number RES - 000 29d. Date signed (Month, Day, Year) 29b. Signature and title of

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son who completed cause of death (Item 23a) (Type, Print) MD

32. Registrar's Signature

Jovember 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Burtonsville Holy Cross Nursing & Rehab Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, **Funeral** Days Months Hours 1**X** M 2□ F New York 220-30-3149 August 23,1915 Director 93 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified Directo Maryland 1 Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20866 U.S.A. 3415 Greencastle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after renent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor School of Public Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Morrison Rider Grace Vance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Friend/POA) 713 Maiden Choice Lane Catonsville, MD 21228 Lon Chestnut 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11-6-2008 Glen Burnie, Maryland 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Ligenses 5555 Twin Knolls Road Columbia, Maryland 21045 art1. Enter the discasshock, or heart fall in or or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** Advanted Dermunhon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Winknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No funeral dire P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 Hospital Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunitha Bhogaville 9801 Georgia Aven e #1-17, Silverspring

32. Registrar's Signature

29c. License number

D0054566

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 3.50 A M 1. Decedent's Name (First, Middle, Last) Month: **Physician** MINSON 2.008 /Medical c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Gardens Nursing Center Baltimore H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day 1 Year (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days 1 □ M 2 🖼 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f show 10a. State 1 les 2 □ No Completed by Funeral Director Maryland Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ New Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No the Medical Exar 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau George Iomesack Mimore W 20e. Method of Dispositi 20b. Place of Disposition (Name of cemetery, crematory or other p 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service License 22. Name and Address of Fecility 23a. Part 1. Enter the tisease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or es a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Physician/Medical the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate ₽ ZNo 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To Nursing Home 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital c within 24 hours af To the Funeral D 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 308, Baltiniare, Mazizoi Dange au

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

aistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician 8100 2008 Jovembei /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TOSPICE 10W50n Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days 1 M 2 F Hours 321-40-0669 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Wedical Examinat must be notified at any Injury or other traumatic event, the Medical Examinat must be notified at any once. 10a. State 10b. County 1 Tes 2 □ No **Funeral Director** olumbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Kidge 2104 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\subseteq \foats \) 2 \(\subseteq \subseteq \text{No}\)

If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rur I Route Number, City or Town, State, Zip Code) Rol Swanfield mother MD Columbia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimae, 10 2008 4 ☐ Donation 5 ☐ Other (Specify) tro 21. Signature of Funeral Service Licensee 22. Name and Addre of Facility 20794 MD 10 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ROSTATE anco **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NOS 3 ☐ Probably 🗡 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate 2 □ No 1 □ Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner?
1 Yes 250No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PLEE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 25642 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 W 10W Soutans

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State Registrar 32 Registrar's Signature

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ň	atter for u	ciai	in the past 12 months?		birth 2 Feta nant at time of o		Ectopic pregnan Other (specify)	су				Month	Day Year
j	the d	ıysi	1 Yes 2 No 9 Unknown	9□Unkn			(-,						
7	requires that een signed b nould be deta	P.	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cause g	iven in Part I.		23e. Did	tobacco u	se contribute to	the cause of death?
dS	uires sign d be	d by								1]2	Yes 2[]No 3∏Pr	robably 4 Unknown
cords,		Completed								040 14/04		045 144	dense finalises sustable
Đ	The law sate has b page 2 sl	E I								24a. Was		prior to death?	utopsy findings available completion of cause of
ਹ	iclan: The la		05.14	-1						1□ Yes	2 2 No	1 ☐ Yes	25XN0
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				hor		(Check only		Ha	spreathouse
6	Physral di	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		28b. Time o	1 0 DOX	4 LI NU		me 5 Res 28d. Describe		Other (Spe	cif)
	Attending r death. ector: After by the fune	ion	1⊒Natural 5 ☐ Pending	(Mor	nth, Day Year)	Injury	W	ork? ⊡Yes 2∐I		zod. Describe	now injuly	y occurred	
JIVISION	deatl ctor: / the	ical	3 Suicide 6 Could no	at he	e of injury - At h	ome farm str				28f Location	(Stroot an	d Number or Ri	ural Route Number,
\geq	after Dire	Certification:	4 ☐ Homicide determin	build	ing, etc. (Speci	fy)	eet, factory, office	,	'	City or To	wn, State)	ara riodie Namber,
	spital ours neral filled		29a. Certifier 1 D4 Certifying	Physician: To the	e best of mv kno	wledge deat	n occurred at the	time, date an	nd place	and due to the	cause(s)	and manner as	s stated
	24 h 24 h e Fur etely	edical	(Check only 2 Medical E	xaminer: On the b	pasis of examination	ation and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time	, date and	place, and due	e to the cause(s)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Me	29b. Signature and title of certifier				29c. Licer	se number			29d. Dat	e signed (Mont	h, Day, Year)
	->-0	(1	~ (5		(1	151	(1)	101	2	- 6 100D
	in		30. Name and address of person v	the completed carr	se of death (Itor	n 23a) (Tuno	Print)	<u> </u>	7.7	/	1 0	AC ILPA	4,000
	12		CAL COM) (D)	V. MY	20a) (Type,	- H-	-27-1	Do	Nt. C	10-	Burn	- 6,2008 pd-2106)
	Sta	ite	31. Date filed (Month, Day, Year)	32. F	Registrar's Sign	ature	3 100	Kraye !	1		0,(0)	, out	w- 2001
	Registr		NOV 1 2 2008	Be Coas	J. St.	book	1						
				di lattera		A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 07:56 PM NOVEMBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSPITAL 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 241-30-4659 Usual Residence of Decedent 1 □ M 2 🗹 F Months Hours Min Yrs. Director Vorth State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f sho 1 TYes 2 □ No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? <u>us</u> Ove Was Decedent Ever in US Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 6 Specify. traumatic event, the Wedical Evan Blae 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Gurname) Be Moore Henry Moore enora 19a. Informant's Name/Relationship (Type. Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Tinsley Road Mill 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mily 5 ☐ Other (Specify) 4 ☐ Donation 21. Signatur of Funeral Service Ligensee Homes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) EPTIC SHOCK Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA weeks Sequentially list conditions, if any, leading to infinite due cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 M No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an After this certificate MELLITUS 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21798 2008 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BHAVANDEE BAJAJ

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar		State o	i Maryia		artment of F rtificate of I	leaith and N Death		leg. No.	008	35839
	Physicia		1. Decedent's Name (2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic	al .	MARY 4a. Facility Name (If n	AGNE			TRICK		r Location of Death	Novemb		, 2008 unty of Death	
ÿ	Examin	er	Saint Jos					Catonsv				ltimor	
	Funeral Director		5. Social Security Nun 216–20–09	85 6. :	Sex 1 □ M 2 X 0 F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day 01/27/	, Year) 1928	Cou	place (State or Foreign intry) yland
	land bw		Usual Residence of D 10a. State	Decedent 10b. County		10c. 0	City, Town or Lo	cation					10d. Inside City Limits
	a-f sh	ctor	Maryland	Baltimo	re	Ec	dmondsor	n Heights					1 □Yes 2 No
	vith the	Funeral Director	10e. Street and Numb		5 .6			10f. Zip Code 21207				of What Cou ed Sta	-
	ns 23c	neral	11. Marital Status	Tera Ro	12. Was Dec	edent Ever in	U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		Race - Amer Black, White	ican Indian,
920	be filed within 72 hours after death with the Maryland that Hyglena. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married		Armed For 1 Yes, Given or D	orces? 2 XNo ive Dates:		1 □ Yes 2 X No	Specify:		Sp	pecify: W	hite
2-0	72 ho "natur edicai	leted	(Specify	15. Decedent's E y only highest g	ducation rade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of word d)	king	16b. Kind	of Business/I	ndustry
121	withir jiena.	Completed by	Elementary/Second	dary (0-12)	College ((1-4or 5+)	1	emaker			Dom	estic	
Maryland 21215-0036	~ - 0 9	BeC	17. Father's Name (F		t)				18. Mother's Nam	,		rname)	
ryla	should be f and Mental P s marked of umatic ever	P	Patrick M		(Type Print)		19b. Maili	na Address (Street	Mary E.			own, State, Z	(ip Code)
	nd 2 sl alth an 27 is r r traur		Mary Jo S			hter			n Road Ba				
Baltimore,	parmit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev once.		20a. Method of Dispo	Cremation 3				osition (Name of matory or other pla Crematory		Date 11/2008		more,	Town, State Maryland
Balti	parmit. Departn Importa any inju		21. Signature of Fun	<u>کا مت</u>)			5311 Edmo		enue Bal	timor	.A. e, Mar	yland 21229
	S		23a. Part . Enter the shock, or heart		natications that one cause on	caused the de	eath. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
X	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	inal	a. Due to	es phe	and M	Sular	Diesse				
	Examiner				b.	The so	cloth	Controll	Della C	Core.			
	be sit	iner	if any, leading to imr cause. Enter Underl Cause (Disease or in	mediate lying	Due to	o (or as a cons	sequence of):						
- -	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) La	ast	c	o (or as a cons	sequence of):						
58760,	tte be (ysiciar ne buri	dical			d								
	ertifica ding ph	/Med	IF FEMALE:		23n if yes o	utcome pf pre	egnancy				23	d. Date of del	ivery
P.O. Box	law requires that the death certifi as been signed by the attending 2 should ba detached for use as	Physician/Me	23b. Was decedent in the past 12 r 1 ☐ Yes 2 🔀 9 ☐ Unknown	months?	1 □Live	birth 2□F gnant at time	Fetal death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	ey		23	Month	Day Year
	s that t ined by a detai	by Ph	Part II. Other signification	cant conditions	contributing to	death but not	resulting in the	underlying cause gi	ven in Part I.				the cause of death?
ord	require sen sig nould b		17 x	1 10 11 1	4 7.00	. (1808	1.20	Hyperdis min vero		1 🗆			robably 4 Unknown
Records,	e la has je 2	Completed	Mes	Source	7. /2	1) /-	Bener	n.s ors			psy ormed?	prior to death?	utopsy findings available completion of cause of
tal		a	25. Was case referr	ed to medical					26. Place of De	1		1 Li Yes	2 □ No
or Vital	is ≥	To B	examiner? 1 ☐ Yes 2 ☐	No			2 ER/Outpatie	SIL SELECT		Home 5 ☐ Resi			ecify)
o uc	iing Pl After ti funeral		27. Manner of Death 1 Matural	n 5	(Mo	e of Injury onth, Day Yea	r) 28b. Time Injury	Wo	uryat ork? ∃Yes 2⊟No	28d. Describe	how injury	occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Pla	ce of injury - A Iding, etc. (Sp		treet, factory, office		28f. Location (City or To	Street and wn, State)	Number or R	ural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one)	1 CertifyIng 2 Medical Ex	aminer: On the	he best of my basis of exar anner stated.	knowledge, dea mination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the curred et the time	cause(s) a , date and p	and manner as place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and	tille of conffier	mh	_			se number 349,7				th, Day, Year)
	6		30. Name and addre	ess of person w	KOT WILL	use of death ((Item 23a) (Pype	Print) LAN	on-kloo				
	St Regist	ate rar	31. Date filed (Mont	th, Day, Year) 1 2 200		Registrar's S	Q11	M. s					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Day DORO THY, **Physician** STOMBAUGH 11:49 pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE , M HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 / 14 / 1915 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F 93 Yrs 188-22-0310 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ns 23a or 28a-f shov must be notified at Glen Burnie Anne Arundel 1 ☐ Yes 2√☐ No Director Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21060 9 Cedar Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: white altimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel G. Cook Clarence A. Block ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Cedar Dr. Glen Burnie MD 21060 Mr Gerald Guiher / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any Injury or once. 11/12/2008 Johnstown, PA Richland Cemetery 4 Donation 5 Other (Specify) 21. Sunature Fune 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 421 Crain Hwy SE Glen Burnie MD 21061 M01364 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INFECTION Physician days LIRINARY TRACT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if only hading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | ned by the a detached f 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>Ş</u> sign 1 be Dementia 2☑No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed Renal 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural Injury I hours after death.

Uneral Director: Af 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in b 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

Zaw Min

31. Date filed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARBOR HOSPITAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

RES_ 00 |

29d. Date signed (Month, Day, Year)

South Hanever Street, Baltimore, MD 21225

NOVEMBER 06 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3564 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 6 2008 **Physician** -07:40AM WEINBER Johnnie Lee Sinkler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** University Specialty Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 1 ▲M 2 ☐ F 65 23, 1943 S. Carolina May Director 212-42-0435 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with tha Maryland 10h County r 28a-f show notified at Y∏Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n ā 21207 USA 5311 Wesley Avenue Pages 1 and 2 should be filed within 72 hours after death nent of Haalth and Mental Hygiane. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes XIXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Auto Technician <u>10th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jake Sinkler Mamie Canty Is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5311 Wesley Avenue Baltimore, Maryland 21207 Gloria Sinkler/ Wife item 27 l 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/14/08 20a. Method of Disposition permit. Pages
Dapartment of I
Important: If Ite
any Injury or o
once. **Ж** Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore, Md 21215 no ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ire. List only one cause on each line. Approximate Interval Between Onset and Death Enter the diveas Immediate Cause (Final TWO WEEK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificata be executed attanding physician and for use as tha burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Yes 2 No 1□ Yes CE 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) CHRONIC 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h. Time of 27. Manner of Death 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours aftar death Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide

Vital or Division

Baltimore, Maryland 21215-0036

within 7

Hospital

State Registrar

DHMH 17 Rev 1/2001

completely the

> WILLCENS 31. Date filed (Month, Day, Year)

BACTIMORE AVE #307 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier (Check only one)

Ty Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00061765

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM/1perPHYS G885 11/12/08 WS State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 9:15 PM **Physician** Haynie Stewart, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRAITIMORE MANOR WOODLAWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F 231-36-6294 JOVENBER 7,1933 YIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Exp. rulest Legical and injury or other traumatic event, Inc. Medical Exp. rulest Legical and 1 ☐ Yes 2 No Director MARYLAND BALTIMORE WOODLAWN 10g. Citizen of What Country? 10e. Street and Number ().5.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: BUACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) TNERNATIONAL PAPER CO. College (1-4or 5+) MACHINIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STEWART JULIA HAYNIE FORTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 707 LYNDHURST ST., BALTIMORE, MD 21229 PINIKIE P. STEWART (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-08-2008 BLACKSTONE, VIRGINIA MT. GAZERINE CEM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
305EPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 N. FULTON AVE, BALTIMORE, MD 21217 earn) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RONARY Immediate Cause (Final RIERY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if they, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es e nonsecuenno ofi Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTER DAWE BUSINESS 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 2 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland /		rtment of F <i>tificate of l</i>		nd Menta		ene 3. No. 2 () () ()	35843
	DI		1. Decedent's Name (First, Middle	e, Last)					2. Date Mor	e of Death	Day Year	3. Time of Death
	Physicia /Medic		Emily Kemp Sch.	lesinger						mber	9 2008	7:05 P ^M
	Examin		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, or		Death		4c. County of Death	
تمير			Broadmead				Cockeysv		Hro o o		Baltimore	
ı	Funeral Director		5. Social Security Number 215–34–8603	4 1 M 0 1 C	e (In yrs. last bi 93	rthday) Yrs.	Months Days		Min. 8. Date (Mo. 07/	e of Birth nth, Day, \ 07/19	(ear) 9. Birth Cou Mary	place (State or Foreign ntry) land
	ryland show	3	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Ba-f s	Director	MD Baltim	ore	Cockey	svi						1 ☐ Yes 2 🔯 No
	th with the 23a or 2	ral Dire	13801 York Road	đ			10f. Zip Code 21030			100	g. Citizen of What Cou U.S.A.	ntry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be retified at once.	d by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Nowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H fYes, specify Cuba I □Yes 2 🙀 No	ispanic Origir n, Mexican, F Specify:	n? (Specify Yes Puerto Rican, e	s or No- etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2-	72 hc 'natu	Completed	15. Decedent (Specify only highes	's Education st grade completed)	16a	. Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation Juring most o	f working	16	6b. Kind of Business/In	ndustry
121	vithin ene. than '	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)						7742724	
7	illed v Hygie ther t	ပ္သ	17. Father's Name (First, Middle,	5+		Tec	hnical Wr		Name (First.	Middle, Ma	<u>Utility</u> aiden Surname)	
aŭ	ould be the Mental arked o atic eve	Be C	Ernest W. Kemp						ly Foar		· · · · · · · · · · · · · · · · · · ·	
$\bar{\leq}$	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Hygiene.	ျှ	19a, Informant's Name/Relationsh	nip (Tvpe. Print)	19	b. Mailir	a Address (Street				City or Town, State, Zi,	p Code)
S	and 2 sealth a n 27 is ner trau		Frances Johnson		12	24 A	rcher Str	eet, E	Bel Air	, MD	21014	
ŗ,	s 1 al		20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of natory or other plac	e)	Date	20	C. Location - City or To	own, State
Ē	Pages nent of int: If its iry or o		1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other (Sp				ation Serv		1/11/20	08 H	Hanover, Ma	aryland
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	Licensee							emation Ser Hanover,	vices, LLC MD 21076
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do	not ent	er the mode of dyin	g, such as ca	ardiac or respir	atory arres	st,	Approximate Interval Between
	Physician /	î	Immediate Cause (Final disease or condition resulting in death)	a. CONC	ESTI	VE	HEA	RT	FA12	-URI	5	Onset and Death
	Examiner			Due to (or as	a consequence	ot):	KART	77/	SFAS	F		O
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):	EYHA	U	JAN 10			
1	cuted nd ransit	Examiner	that initiated events	c. HVP	KRL.	1191	DEMI.	A				
Ö,	e exe		resulting in death) Last	Due to (or as	a consequence	of):						
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	requires that the death certific peen signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pregnanc	y			23d. Date of deliv	/ery Day Year
rds, P.	quires that n signed by	δ	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the ur	nderlying cause give	en in Part I.	236	e. Did toba	acco use contribute to	the cause of death?
Rec	aw as k	Completed								a. Was an autopsy performe	prior to co death?	opsy findings available ompletion of cause of
	ian; '	BeC	25. Was case referred to medical					26. Place of	f Death (Check			2 🗆 100
	Physician; r this certific ral director, I	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/O	utpatier	t 3 DOA Oth	er: 4 🖸 Nursi	sing Home 5[Residen	ce 6 Other (Spec	ify)
\subseteq	ng fte	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		ry 28b. y, Year)	Time of Injury	Worl	yat (? Yes 2 □ No		scribe how	injury occurred	
Division of	l or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		ury - At home, for a second control of the control	arm, str	eet, factory, office		28f. Loc City	ation (Stre	eet and Number or Rur State)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examination a	je, deatl nd/or in	n occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due occurred at th	e to the car e time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	omple	Mec	29b. Signature and title of certifier	and mainler ste			29c. Licens	e number		290	d. Date signed (Month)	, Day, Year)
	- > F U		BALLONIA	(ALLA)	11.7	me	1 DZ	820	2		11/10/2	2008
	re		30. Name and address of person	who completed cause of d	eath (lem 23a)	(Type,	Print)	VINR	V Ph		ACINIA	111/21/1
		10	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1.	10001	yUNI	VIV	1	UKEYS	VILLIA
	Sta Registr		NOV 1 9	2008		de	made 1					

DHMH 17 Rev 1/2001

3/ at per Beause

Emily Schleamger 1119108 7:05 Pm.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 **Physician** 2040 PM A-YMOND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL KANDALLSTOWN BALTIMURE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 216-52-4172 1 🔀 M. 2 🗆 F 560 Yrs JANUARY 13,1952 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f short to Medical Examiner must be notified at 1 XYes 2 No Director MARYLAND BALTIMORE 10e. Street and Number 10g. Citizen of What Country? LARINTH permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, If a Medical Exprinter must any Injury or other traumatic event, If a Medical Exprinter must once. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE CONSTRUCTION HOME IMPROVEMENT CO. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHIELDS PRESTON CHARIT) POWELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OLIVIA SHIELDS RD., BALTIMORE, MD 21215 (WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MIT. ZION CEMETERY 11-14-2008 LANSDOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 503EPH H. BROWN JR, FUNERAL HOME elliamo 2140 N. FULTON AVE., BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the charge Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, physician Completed by Physician/Medical as the signed by the attending I IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

EVIN- JEAN

31. Date filed (Month, Day, Year)

NOV 12

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

GANN

32 Registrar's Signature

MC

2008

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

ROAD, RANDAUSTOWN, MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 1:10 A M Donald David Spriggs November 2008 08, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2425 Woodcroft Road Parkville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Director 218-32-0097 72 02/06/1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at Parkville 1 ☐ Yes 2 X No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 2425 Woodcroft Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Old El Paso Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be Janet Muth David Samuel Spriggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2425 Woodcroft Road , Parkville , MD 21234 Kay V. Spriggs/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/11/08 Parkwood Cemetery Parkville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services— Parkville 8800 Harford Road Parkville, MD 21234 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest bck, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immulate Cause (Final disease or condition resulting in death) 00 Physician 6 izeas /Medical Due to (or as a consequence of) 60 years **Examiner** agrett Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a considuince of physician and stransit is the burial-transit A pue Exami death certificate be exec Due to (or as a consequence of): Box 68760 Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David In Cellins mb 67cl N-Charler St., Suite 4101, Balton, MD 21204 31. Date filed (Month, Day, Year) State 2008 Registrar

(Check only one)

29b. Signature and title of pertify

32. Registrar's Signature



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0020650

29d. Date signed (Month, Day, Year)

Nov. 10, 2008

DHMH 17 Rev 1/2001

3:25

2008

NOVEMBER

SHAFFER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 5, ₽008 6:28FM **Physician** sey more /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number). 4b. City, Town, or Location of Death Examiner Center Towson 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 24 1920 Social Security Number **Funeral** Hours Months Min. Days 212.32.0580 1 □ M 2 X F 81 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exprense must be notified at MID Baltimore 1 XYes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6320 Greenspring Avenue Apt. 101 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: Black 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1.4or 5+) Elementary/Secondary (0-12) Hospital 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Inomas Venev Burrell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 Avenue Apt. 101 if item 27 is Department of Health Important: If Item 27 any Injury or other tronge. Margaret 4320 Greenspung 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, MD 1 Burial 2 ☐ Cremation 10/08 Arbutus Memorial 4 Donation 5 Other (Specify) C. Greene Purunu 21. Signature of Funeral Service License 22. Name and Address of Facility Vaugur Vau 8728 Libert Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOGENIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>6</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗆 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar FRANCIS

31. Date filed (Month, Day, Year)

7601 OSLER DRIVE, TOWSON.

MARYLAND 21204

KH00,

M.D.

32. Registrar's Signature

TAT-TEE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 8, 2008 3:10 P^{M} November Ellen Gage Southworth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 10906 Bucknell Drive, #1223 Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
April 5, 1947 Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🛛 F 61 213-48-7867 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be nutfilled at 1 ∏Yes 2 N No Funeral Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10906 Bucknell Drive, #1223 20902 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States nd 2 should be filed within lith and Mental Hygiene.
27 is marked other than "r traumatic event, Ire Nee Elementary/Secondary (0-12) College (1-4or 5+) Staff Member Congress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winthrop Morton Southworth, Jr. Marion Gage White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 11927 Parkside Drive, Fairfax, Virginia 22033 Health Deborah S. Bishop/Sister 27 permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Montgomery Crematorium, Inc. 2008 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service-Licensee Ungefette Samus M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or mention Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown p signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 certificate 1 ☐Yes 2 ANo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∭XYes 2∐No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Division of Vital Records, the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

Box 68760,

DHMH 17 Rev 1/2001

State Registrar

Medical

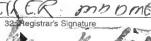
29a. Certifier

(Check only

Rignature and title of certifier

31. Date filed (Month, Day, Year) 12 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



mIME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D00478

29d. Date signed (Month, Day, Year)

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_			Registrar Decedent's Name (First, Middle, Last	t)		Octun	0010 07 1		2. Date of Dea	th	LUO	3. Time of Death
	Physicia /Medic	an		amae1	Suar	ez			November 1	er 5, 2	008	1536 M
	Examin		4a. Facility Name (If not institution, give	-		4b.	Roc	Location of Death	ı	4c. County	1	omery
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the N	r 28a-	irect	10e. Street and Number			11	0f. Zip Code		4	I0g. Citizen of	What Cour	ntry?
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_ e		10 B	Mario	Jose S	Suarez	3		Lucia	a 	Telle	z	
Taryla 2 should	th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (7		1	•	•	and Number or Ru				
	or Health item 27 r other tr		Mario J. Suarez	/ Father	20h Place			Park Dr.	, Gaithe:	rsburg,		
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	ledical aminer	Ш	resulting in death)	Due to (or as a	consequenc	ce of):						
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Division of Vital Records, P.O To the Hospital or Attending Physician: The law requires that the	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and title of certifier	and manner state	ed.			se number		29d. Date sign		
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•	2)		30. Name and address of person who	completed cause of de	ath (Item 23	Ba) (Type, Prir	nt) 2/0	10042	Lical	DAIK	Dr	
	4			SCAFR				Ve . 90	1127	mo	205	702
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	1 September 1	100)				

Antoinette Shelton	1- For State	State of Maryla	nd / Departme <i>Certifica</i>			Mental H		Reg. No. 20	18 3585
Physician/	1. Decedent's Name (Fi	irst, Middle,Last)					2. Date of Dea		3. Time of Death
Medical Examiner	MATOTIALITI	E NICOLE SHELT					Novembe	er 7, 2008	0820 hrs
	4a. Facility Name (if no 5304 Eastbury	ot institution, give street and num Avenue	nber)		r, Town, or Lo ti m o re	ocation of Deat	h	4c. County of Dea	ath .
Funeral	5. Social Security Numb	ber 6. Sex	7. Age (In yrs. last birth			If Under 24Hr Hours Mi		irth(MM/DD/YYYY) 9. E Fore	eian
Director	217-84-021	13 1 M 2X F	39	Yrs.	ths Days	nours Ivii	JUNE 1	5, 1969 °	Country) MD
4	Usual Residence of De 10a. State 10b	ecedent b. County	10c. City, Town o	r Location					10d. Inside City Limits
ow ar	Toa. State	5. County	,						1 X Yes 2 No
syland tone tone	MD 10e. Street and Numbe	ar	BALTIM		Zip Code			10g. Citizen of What Co	
the Marylanc a or 28a-f sh tiffied at onc.									
with t	11. Marital Status			13. Was Dece			Specify Yes or N		erican Indian, Black,
death with or items 23s nust be not uneral	1 X Never Married	2 Married Armed Fo	rces? 2 X No	If Yes, spo	cify Cuban, N	Mexican, Puerl	o Rican, etc.)	White, etc.	
safter carral", or	3 Widowed	4 Divorced If Yes, Give Year or Dates:			2 X No			Specify: BL	
hours Exam ed 1	15. Decedent's Educa	ation (Specify only highest grad	d			n (Give kind of OO NOT use re		16b. Kind of Busines	s/Industry
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21215-00; uld be filed with Mental Hygiene marked other to event, the Mental To Be Com	The second secon	SHELTON, SR.				OROTHY	CLOUD		
Baltimore, MD 21215-0036 Dearmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be motified at once. To Be Completed by Funeral Director	19a. Informant's Name/	/Relationship (Type, Print)	19b.	Mailing Addr	ess (Street a	and Number or	Rural Route Nu	ımber, City or Town, Sta	ate, Zip Code)
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P. S. Ja.		Cremation 3 Removal fro		ry or other pla					
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	21. Signature of Funera	al Service Licen	7					AVIS, JR. I	
Physician	2 art I. Enter the	isease, or complications that ca	used the death. Do not	enter the mod	-U8 E.F le of dying, su	uch as cardiac	or respiratory a	ALTIMORE, Interest, shock, or heart	Approximate Interval
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68760, certificate be nding physici ise as the builties as the builties is an //wed	IF FEMALE: 23b. Was decedent pre-	23c. If yes, c	outcome of pregnancy	, 254,2	.7 , pcr			23d. Date of deliv	
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w requests been shoul	h							opsy prior t	autopsy findings available to completion of cause of
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Division of Nours after data. Division of Attending Ph. Bours after death. Beral Director: After to filled in by the funeral Certification: T.	3 Suicide 6	Could not be determined (Specify)	, ,		,		or Town,	State)	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for Medical Certification: To Be Completed by Physis		ertifying Physician: To the best edical Examiner:On the basis of							
To con	29b, Signature and title	and manner st e of certifier	ated.	Т	29c. License	number		29d. Date signed (Month, Day, Year)
	lamone	- Me Uhill	{		O.C.M	1.E.		November 8, 2	2008
b		s of person who completed caus	e of death (Item 23a)						
V	Margarita Kore			111 Penn	Street, Bal	Itimore, MD	21201		
State Registra			gistrar's Signature	Speak!					
DHMH 17 Rev 1/2001	NU V	T to conn		GINAL					20115
			UN.	T					OCME

08-08366 Peter M. Sandor

Pete	er M. Sandor		1- For State Registrar	State	e of Maryla	-	artment o <i>rtificate o</i>			Ment	al Hyg		Reg. No.	2	008	358
N/I o	Physicia		Decedent's Name (First, —		/	-						Date of De Month	Day	Year		e of Death
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			10112 Hellingly P			riber)		•		Village				ntgome		
	Funeral		5. Social Security Number	6.5	Sex	7. Age (In yrs. I	last birthday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of B	irth(MM/DI	D/YYYY)	9. Birthplace	(State or
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20	Maryl 28a-	rect	10e. Street and Number					10f. Zîp	Code				10g. Citize	n of What	Country?	,
/	h the 23a or notifie	Funeral Director	10112 Helli	ng1y					879						States	
	ith will tems 3	Jera	11. Marital Status 1 Never Married 2	Marrie				as Deceder Yes, specify				cify Yes or N can, etc.)	0- 1	4. Race White,	American Indetc.	lian, Black,
	er des				1 Yes ed If Yes, Give Year	2 X No		Yes 2	/ No	on an if a				pecify:	White	
	bours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once.	i by	15. Decedent's Education		or Dates		16a. Decede		~		ind of wor	rk done			ness/Industry	
	72 hou	Completed	Elementary/Secondary (College (1-			nost of work							,	
	036 ithin me. r than	ldu			3		Purc	hasin	e Ae	ent			Cor	nstru	ction	
	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, N	iddle, Las					11	8.Mother's	Name (F	irst, Middle,	Maiden S	urname)	V. L. 1.V.L.	
	121 d be fi ental arked	Be	Frank Sando							Blone	lena	Rhode	S			
	D 2 should and M 7 is m	욘	19a. Informant's Name/Rel				3								State, Zip Co	ode)
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Andrew Sand 20a. Method of Disposition	or/So	on	20b.	2306 Place of Dispo	Lava sition (Nam	Lan e of cem	e Ki	illee	Pate TX	7654	cation - C	ity or Town,	State
	Ore ges 1 t of H		1 X Burial 2 Cre	nation 3	Removal fro	m State	crematory or o	ther nlace)								
	Baltimore, permit Pages I ar Department of Hee mportant: If ite njury or other tr	-	4 Donation 5 Ott 21. Signature of Funeral Se			A	11 Sou	s cen	ddroop	of Facility	11/	13/08	Ger	mant	own, M	ID remation
	Bal Dermi Impo					1527	22. S	Perula	o C	Or Facility イファ	COLO	t N	uner	9	na C	emation .
	Physician	\dashv	23a. Part I. Enter the disea	se, or con	nplications that ca	used the death	. Do not enter	the mode o	dying, s	uch as ca	rdiac or re	espiratory a	rrest, shock	k, or heart	Appi	roximate Interval
	/Medical	-	failure. List only one Immediate Cause (Final di			osclero	otic ca	rdiov.	ascu	lar d	disea	ase			Betv	ween Onset and Death
	xaminer		or condition resulting in de		Due to (or as a											
		إيا	Sequentially list conditions		b Due to (or as a										_	
		edical Examiner	if any, leading to immediate cause. Enter Underlying C (Disease or injury that initial	ause	c.	consequence o	or):									
	si d	Xar	events resulting in death)		Due to (or as a	consequence o	of):									<u> </u>
7	50, te be executed tysician and burial - transit	E I	- William III		d	23a,27,	DorME	~886	12/	15 //	אר אר	r				
	e be e	edic	XUNPENDED				Ī	gooo	12/	15 /(70 11					
	Box 68760, a death certificate be the attending physicied for use as the buri	2	IF FEMALE: 23b. Was decedent pregnar	t in the	23c. If yes, o	outcome of preg		etal death	3	Ectopic	pregnanc	v		Date of de	elivery Day	Year
	th cer	sician/N	past 12 months?	1	4 Pregna	ant at time of de		ther (Spec	ify)						,	
	Bo ne dea the a	Phys	1 Yes 2 No 9	Unknov	9 Olikilo											
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by F	Part II. Other significant of	onditions	s contributing to	death but not r	esulting in the	underlying	cause giv	ven in Par	t I.				7	use of death?
	S, quires en sig	ted										24a. Was				indings available
	aw renas be	ple										auto	ppsy ormed?	pric		ion of cause of
	Rec The Tre I reate page	Completed										1 Yes			Yes	2 No
	Division of Vital Records, nat or Attending Physician: The law require rs after death. a) Director: After this certificate has been sited in by the funeral director, page 2 should b	Be	25. Was case referred to m examiner?		Hospital:		1		ic	of Death (-	1			
	Physical distribution	유	1 ✓ Yes 2 No.)	<u> </u>	npatient 2	ER/Outpatien		,,,	at Work?		Home 5			Other: Scene	
	nding th. :: Aft	Ë	1 X Natural 5	Pending	28a. Date ((Month,	Day,Year)	200. Title of	mjury 2		es 2		ou. Describe	riow injury	yoccurred	ı	
	isic	Certification:	2 Accident	Investiga	ation 280 Place	of Injury - At h	ome, farm, stre	et. factory.				8f. Location	(Street and	d Number	or Rural Rou	ite Number, City
7	Div ital or ral Di lled in	틸	3 Suicide 6 4 Homicide	Could no determin	ot be		,,	,,				or Town,				is nongon, only
	Hosp 24 hou Fune tely fi		20a Certifier	ng Physi	cian: To the best	of my knowled	lge, death occu	rred at the	time, dat	e and plac	ce, and du	ue to the cau	ise(s) and	manner a	s stated.	
	o the	Medical	(4	-	er:On the basis o	f examination a	-									e(s)
	F 3 F 3	š	29b. Signature and title of	ertifier	_ drig mamor se	atou.		29c.	License	number			29d. Da	ate signed	(Month, Da	y, Year)
			Morganie	1	ne Usmi	u			O.C.N	1.E.			Nove	mber 8	, 2008	
	1	ŀ	30. Name and address of p		· ·	,										
	N		Margarita Korell N		Assistant Med			enn Stre	et, Ba	Itimore,	MD 21	201				
	St	ate	31. Date filed (Martin Day),	ear ₂ 2	2008 32	gistrar's Signati	K Do	We								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	R	1- For State Certificate of Death Registrar		g. No.	0 0000
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last) Alexis Southworth	2. Date of Death Month November		3/Time of Death U
Medical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatr		4c. County of Death	
		Johns Hopkins Hospital Baltimore	1	N/A	(0)
Funeral Director		5. Social Security Number 6. Sex 1 Months 031-30-7164 6. Sex 1 Months 04 Months 04 Months 05 Months 05 Months 05 Months 05 Months 06 Months 07 Mon	_	h(MM/DD/YYYY) 9. Bir Foreig 1943 Côi	
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.	5	MD Anne Arundel Odenton			1 Yes 2 X No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. In the Maryland of the than "natural", or items 23a or 28a-f shour util. If item 77 is marked other than "natural", or items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once.	3	10e. Street and Number 10f. Zip Code 21113	10	og. Citizen of What Cou USA	ntry?
with th	ਚ ├	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer	ican Indian, Black,
or death v		1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	o Rican, etc.)	White, etc. Specify: Wh	ite
urs afte	⋧┞	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/	
n 72 ho	pajaidillo	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Clinical Social Worker		Private Pr	raction
21215-0036 old be filed within 7 Mental Hygiene. marked other than c event, the Medica	Ę		e (First, Middle, N		actice
1215- be filed antal Hy irked of	e n	Hunter Wilson Blake, Sr. Nancy	Yanishy		
MD 27 d 2 should tht and Mo n 27 is ms tumatic er	_	19a. Informant's Name/Relationship (Type, Print) Jon Phillip Southworth-husband 19b. Mailing Address (Street and Number or 8603 Wintergreen Court			
e, M I and 2 Health item 2	- 1-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I are Department of He Important: If ite Important: If ite Important or other to		Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify: Metro Crematory, Inc.	07/2008	Baltimore	, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If tiem 27 is marked other triumy or other traumatic event, the Med		21. Signature of Funeral Series Licensee H. Williams 22. Name and Address of Facility Cremation Society 299 Frederick Roa	of Mary	land, Inc.	21228
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Medical. "xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
	-	Sequentially list conditions, b			
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
nd ransit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
8760, ificate be lightly physicist the burille.		IF FEMALE: 23b. Was decedent pregnant in the specific growth 2 constitution of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregramment	nancy	23d. Date of deliver Month	ry Day Year
Box 687 e death certifi the attending ed for use as t	Physician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			ĺ
by the	ڇَٰ ا	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
s, P.O. Be iires that the dea is signed by the added de detached for the additional to the additional		End-stage renal disease status post renal transplants	1 Yes	s 2 No 3 Pro	obably 4 🗸 Unknown
ords ** requires to the special should to the special should to the special should to the special spe	Completed by		24a. Was autop	osy prior to	utopsy findings available completion of cause of
Vital Records hysician: The law requi this certificate has been I director, page 2 should	Ę		perfo 1 Yes	rmed? death? 2 No 1 🗸 Y	res 2 No
ician: s certifi rector,	å	25. Was case referred to medical examiner? 1 Ves 2 No Other Death (Check Place of Death	k only one) sing Home 5	Residence 6 Other	or.
of V ing Phys After thi uneral di	<u> </u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurred	
ion frendin leath. for: A	atio	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No			
Division of Vital Records, P.O tall or Attending Physician: The law requires that the rate death. **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaction.	Certification:	3 Suicide 6 Could not be determined (Specific)	28f. Location (3 or Town, 5		tural Route Number, City
id po		4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the caus	se(s) and manner as sta and place, and due to t	ated. the cause(s)
To To com	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
		fall o.c.m.e.		November 6, 20	008
4		30. Name and address of person who completed eduse of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201		
Star	te	31. Date filed (Month, Ray, Year) 2000 32. Registrar's Signature			
Registra	ar	NOV 1 2 2008 See May 15 August 15 Au			

Amend #30 per DVR g885 11/12/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar			Cer	tificate of l	Death		R	eg. No. 2	008	35854
	Physicia	an	1. Decedent's Name (First, Middle,	Last)						2. Date of Dear Month	Day	Year	3. Time of Death
	/Medic		ROSE				SMALL			NOVEMBE		2008	12:35P ^M
	Examin	er	4a. Facility Name (If not institution,	•	TU CTD		4b. City, Town, or PIKESVIL		f Death			inty of Death	
			RUXTON OF PIKE 5. Social Security Number		e (In yrs. last birti	hdav)	If Under 1 Year	L C If Under:	24 Hrs.]	8. Date of Birth	1	g. Birthp	lace (State or Foreign
	Funeral Director		212-28-2191	1 □ M 2 K F	. ,	Yrs.	Months Days	Hours	Min.	(Month, Day 12/19/	(Year)	Cour	MD MD
	ס		Usual Residence of Decedent										
	show	_	10a. State 10b. County		10c. City, Town							1	0d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	Director	MD CARR	.0LL	WEST	IMIN	ISTER				IO Oiking	-618/56-0	
	vith th	声	10e. Street and Number				10f. Zip Code	1157			rug. Citizen	of What Cour	ury?
	eath v	eral	1809 BENEDICT	RUAD 12. Was Decedent B	Ever in U.S.	13. V		1157 Iispanic Ori	ain? (Spe	ecify Yes or No-	14.	USA Race - Americ	can Indian,
(0	fter d r Item iner	핊	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? 1 ☐ Yes 2 ☐ N	No.	1	/as Decedent of H Yes, specify Cuba		, Puerto	Rican, etc.)		Black, White,	etc.
036	urs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2ሺNo	Specify:			Spe	ecify: WHI	. 1 5
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	Completed by Funeral	15. Decedent's (Specify only highest	Education grade completed)	16a.	(Give k	ent's Usual Occup	during mos	t of worki	ng	16b. Kind o	of Business/In	dustry
121	ithin han "	ld III	Elementary/Secondary (0-12)	College (1-4or 5	+)		O NOT use retired NISTRATI	,	1212	ΔΝΤ	C	ORPORA	TION
2	e filed within al Hygiene. I other than '	ပိ	12 17. Father's Name (First, Middle, L	ast)	, , , , , , , , , , , , , , , , , , ,	נויוטא	וואווכווו.			(First, Middle,			1101
Maryland	ld be f lental ked o	o Be	ZELIG		1	LEV I	тт	7	OLLI	E			AIKEN
Σ	2 shoul and M Is mar! aumat!	은	19a. Informant's Name/Relationsh	p (Type. Print)			g Address (Street				r, City or To	wn, State, Zij	Code)
	1 and 2 Health a em 27 is		STEVEN SMALL	/ SON	1	1809	BENEDIO	CT ROA	ND, W	ESTMINS	STER,	MD 21	157
ore	ss 1 a of He item		20a. Method of Disposition		20b. Place of cemeter	Dispos y, crem	ition (Name of atory or other place	ce)		Date	20c. Locati	on - City or To	own, State
altimore,	Page ment ant; I		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		HEBREV	W Y	OUNG MENS	5 1	1/11	./2008	BALT	IMORE,	MD
Balt	permit. Pages 1 Department of I- Important: If ite any Injury or ot		21. Signature of Funeral Service L	icensee			Name and Addre			L LEVIN			
_	<u></u>		15000)	d	>_							VILLE.	MD 21208
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	omplications that caused nly one cause on each lir	I the death. Do n ne.	not ente	1		cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician / Medical		Immediate Cause (Final disease or condition resulting in death)	a	Mers		Jement	1 0					
-	Examiner		,	Due to (or as	a consequence of	ot):							
Ļ		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequence of	of):							
V	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C									
, 0,	e exe ian al urial-t		resulting in death) Last	Due to (or as	a consequence of	of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical	`	d									
×	certification of ding page 28		IF FEMALE:	23c. If yes, outcome	of pregnancy						234	Date of deliv	erv
Bo	atten for us	cjan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		Ectopic pregnand Other (specify) _	СУ			230	. Date of deliv Month	Day Year
0	that the de ned by the a detached f	Physician	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unknown			(-, , / -						
٠ <u>,</u>	s that med b		Part II. Other significant conditio	ns contributing to death b	ut not resulting in	the ur	derlying cause giv	en in Part I		23e. Did to	obacco use	contribute to	he cause of death?
ırd	en siç ould b	edk	Persperel Vi	escular	rease			···		1 🗆 Y	′es 2□N	lo 3□ Pro	bably 4 Unknown
Division of Vital Records,	The law requires that the death ate base been signed by the atter bage 2 should be detached for u	Completed by								24a. Was a		4b. Were aut	opsy findings available empletion of cause of
<u>=</u>		Som								perfoi 1 □ Yes	rmed? 2 X No	death? 1 □ Yes	2 🗆 No
/ita	ysician: Thesis certificate director, pag	Be	25. Was case referred to medical examiner?	1			100		e of Deat	h (Check only o	ne)		
of \	ys di is	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatien	t 3 □ DOA Ou 28c. Inju		ursing Ho	me 5 Residence Residence Residence 1			fy)
no	ling After fune	tjon	1 Natural 5 ☐ Pending	(Month, Da		njury	Woi	rk?]Yes 2.□	No	Zou. Describe i	low injury or	Scurred	
/isi	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Inj	ury - At home, fa	rm, stre				28f. Location (S	Street and N	lumber or Rui	al Route Number,
<u>S</u>	afor safter	erti	4 ☐ Homicide determi	building, et	c. (Specify)				ļ	City or Tow	vn, State)		
	e Hospital 24 hours a Funeral I etely filled		29a. Certifier 1 Certifyin	g Physician: To the best Examiner: On the basis of	of my knowledge	e, death	occurred at the t	ime, date a	nd place	and due to the	cause(s) ar	nd manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical	one)	and manner st									
_	Neith Con Con Con Con Con Con Con Con Con Con	2	29b. Signature and title of certifier	2			29c. Licens					igned (Month	Day, Idai)
			March	200		/T:		05333	> †		11 10	2/08	
-	m		30. Name and address of person of DOrothy Mae Sea	·)3 Ra	ltima	ore. MD	21209		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	dogo	Partie 20	, uu.	IIII	, in/			
	Registr		NAV 1 2 2	UUO STEER	I Shir for	27.00							

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			1 – For State Registrar	State of Mar	yland / I	•	rtment of H tificate of L			giene Reg. No. j	200	R	35855
F	Physicia	an	1. Decedent's Name (First, Middle, Last)	o o					2. Date of Dea	ath Day	Ye	ar	3. Time of Death
	/Medic		ANNA MADELIN		EGLER				Novembe	er 7,	2008	3	8:05 A M
	Examin	er	4a. Facility Name (If not institution, give s		0 5		4b. City, Town, or	Location of Deat	h		County of D Ltimo		
4	Funeral		Greater Baltimore 5. Social Security Number 6. Sex		(In yrs. last bii		Towson If Under 1 Year	If Under 24 Hrs	8. Date of Birt			Birthp	lace (State or Foreign
	Director			M 2 F		Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da SFPT 2	y, Year)		Coun	try) AND
	and w		Usual Residence of Decedent 10a, State 10b. County		IOc. City, Tow	n or Loc	ation				_7 -11		Od. Inside City Limits
	// Aaryla	o	MARYLAND BALTIMORE		Too. Oily, Tow		DWSON					1	1 ☐ Yes 2 No
	r 28a-	irect	10e. Street and Number	0001111		-	10f. Zip Code			10g. Citiz	en of What	t Coun	
	th with	Funeral Director	615 CHESTNUT AVEN	UE			21	204			U:	SA	
	r deal	uner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of Hi	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 1	4. Race - A		
320	be filed within 72 hours after death with the Maryland ttal Hyglene. dother than "natural", or items 23a or 28a-f show event, the "Addral Exatr har rust be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			□Yes 212 No	Specify:			Specify:		IITE
5-0036	2 hou		15. Decedent's Educ	ation	16a	. Deced	ent's Usual Occupa	ation		16b. Kir	nd of Busine	ess/Inc	lustry
Z	ithin 7 ne. nan "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			ind of work done d O NOT use retired,))	rking	^	-		
7	fygier her th	S	17. Father's Name (First, Middle, Last)			НС	MEMAKER	40 Mathada Nas	me (First, Middle,		VN RES	SID	ENCE
yland	ld be fi ental } ked ot ic ever	Be C	EDWRAD FORD HAA	ς					MARIE KO		,		
<u>چ</u>	should be and Menta marked umatic ev	_T	19a. Informant's Name/Relationship (Ty)		196	. Mailing	Address (Street a					te, Zip	Code)
(Sa	and 2 saith a 127 is		MRS. JOY S. RILEY	(Daughte			MONT COU				AND 2		_
0	les 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		20b. Place o cemete		ition (Name of atory or other place		Date		cation - City		
Банттоге	t. Pag tment tant:		4 Donation 5 Other (Specify)		Parkw	OQD_	CEMETERY		0/2008	Park	VILLE	۱ ر	MARYLAND
g	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Furnital Service License MARTIN D. LAW	200201		M]	Name and Addres	11 1/1 1 1 1 1	FUNERAL	_ HON			1010
		13	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	cations that caused th	e death. Do	not ente	r the mode of dyin	g, such as cardia	c or respiratory a	rrest,	RYLANI) <u>Z</u> .	1212 Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Intracra		Ble	ed						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):							
		Je.	Sequentially list conditions,	Due to (cres a r	consulçuence	eth-							
	cuted nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events										
Š,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):							
08/00,	icate physi	edical										+	
XO D	n certific		IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of						2	3d. Date of	f delive	ery
о С	e law requires that the death cer has been signed by the attendir le 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Month		Day Year
Ţ.	that the ed by detach		Part II. Other significant conditions con	tributing to death but	not resultina i	n the un	derlying cause give	en in Part I.	23e. Did to	obacco us	se contribu	te to th	e cause of death?
ecords,	quires in sign	d by	Hypertension						1 🗆 1	Yes 2	No 3	Prob	ably 4 🔀 Unknown
ဝ၁	aw rei	Completed	Chronic Kidne	n dispase					24a. Was		24b. Wer	e auto	psy findings available appletion of cause of
ř =	ding Physician: The i h. After this certificate h funeral director, page	E		1					autop perfo 1 □ Yes	rmed?	deat	th?	2 No
VII	Iclan: Sertific Setor,	Be (25. Was case referred to medical examiner?						ath (Check only o	-			
5	Phys r this ral dir	<u>ان</u>	1 ☐ Yes 2 No 27. Manner of Death	ospital: 1 Impatient 28a. Date of Injury	2 ER/O	utpatient Time of		4 LI Nursing F	lome 5 Resid			Specif	y)
5	th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year)	Injury	28c. Injury Work M _ 1 □ \	rai ? Yes 2∐No	28d. Describe I	now injury	occurred		
DIVISION	Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At home, fa	rm, stre			28f. Location (5	Street and	d Number o	r Rura	I Route Number,
5	ital or rs after ral Dir fed in	Cert	4 E Homeide	building, etc.	(Specify)				City or Tov	wii, State)			
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death within 24 hours after death. To the tunneral Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one) Certifying Physical Control one)	sician: To the best of ner: On the basis of e and manner state	examination ar	e, death nd/or inv	occurred at the tin estigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and mann- place, and	er as s due to	tated. the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	e signed (M	fonth,	Day, Year)
	Á		2 mt 2 s	2	MO		Doc	6658	4		1/7	1	28
	0		30. Name and address of person who co	mpleted cause of dea	ith (Item 23a)	(Type, F	rint)						
		10	MITSH TRANSPORTA	32. Registrar		ST	EST TO	wsen, r	10 212	44			
	Sta Registr		NOV 1 2 20	Pies	i A	A.	20 83						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35856 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 3 Month Year **Physician** 10:30 PM STEINBERG MORRIS 2002 O /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 12 M 2□ F Months 93 216-42-6245 01/10/1915 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 VYYes 2 □ No Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6307 LINCOLN AVENUE 21209 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ABRAHAM STEINBERG PEARL MERVIS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED STEINBERG / WIFE 6307 LINCOLN AVENUE, BALTIMORE, MD 20b. Place of Disposition (Name of Carne in Control of Spiner place) BETH ISRAEL 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/09/2008 BALTIMORE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANOTIC NCEPHALOPATHY disease or condition resulting in death) Due to (or as a consequence of): HEMORKHAGE NTRACRANIM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 11 No 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notifled at

"natural", or items

is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner.

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum once.

Saltimore, Maryland 21215-0036

death with

the burial-tran physician for use as ed by the a detached f

Physician/Medical Examiner Completed by Be Certification: To

Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, cate has been signed in page 2 should be det certificate Hospital or Attending Physician: funeral director, After this n 24 hours after death.

le Funeral Director: Af filled in by completely within 24 the

31. Date filed (Month, Day, Year) State 2 1 Registrar

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

and manner stated. 29b. Signature and title of certifier MYSICIAN

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

29c. License number 00064533

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LC N DTE - HGS 2(N GENINTRIC 2434 W. BELVEDERE AVE - BAUTIMORE MD 21215 LABATUNDE TANI M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

32. Registrar's Signat ask) 2008

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Amend 19a,perFhG885 11/14/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar		epartment <i>Certificate</i>			- '	0 0	08 35857
3	Dharaini		Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Ruth Rita Tanner						11-10-		Year 6:40A M
	Examin	er	4a. Facility Name (If not institution, give Brightview	street and number)		4b. City, To	own, or Locatio	n of Death		4c. County	
18.	Funeral		Social Security Number 6. S		In yrs. last birtl	nday) If Under 1		er 24 Hrs.	8. Date of Birth	h	9. Birthplace (State or Foreign
E	Director		216-24-9322 1 Usual Residence of Decedent	□ M 2Ā F	81	rs.	Days Hours	s Min.	(Month, Day	1927	Country) MD
	/land ow at		10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
	e Mar a-f sh tifled	ctor	MD Harfor	đ	Be1	Air					1 ☐ Yes 21 No
	vith th	Director	10e. Street and Number			10f. Zip C				10g. Citizen of W	/hat Country?
	leath v	Funeral	1718 Pine Forest	12. Was Decedent Ev	er in U.S.		21014	Origin? (Spe	cify Yes or No-	USA 14. Bace	- American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decede If Yes, specif			Rican, etc.)		White etc.
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Usual (Give kind of work	Occupation	nast of warkin	na l	16b. Kind of Bus	siness/Industry
21215-0036	within sne. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use pervisor	retired)	ioot or working		TT 1 t.1. 7	
d 2	Hygid other ent, th	Be Co	17. Father's Name (First, Middle, Last)		bu	pervisor	18. Mo	ther's Name		Maiden Surname	Insur. Company
/lan	Menta Menta arked artic ev	To B	John Tanner Jr.				E1	izabet	th Hube	r	
Maryland	l 2 sho h and r is ma		19a. Informant's Name/Relationship (7 Kehl Carol Kahl (Niec	ype. Print)		Mailing Address (State, Zip Code)
e,	Healt tem 2		20a. Method of Disposition		20b. Place of	718 Pine Disposition (Name	e of		ate Air		City or Town, State
altimore,	t. Pages rtment of rtant: if i		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	2	St. Jo			11-14-		Fulle	erton
Ba	Depa impo any i		21. Signature of Funeral Service Lice	06		9705 B	elair R	Road No	ottingh	Funeral am, Md.	
H			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final						r respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Meta Due to (or as a c		- Ovari	an ca	ncer			lyear
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). Box	e death c he attend led for us	Physician/Me	in the past 12 months?	23c. If yes, outcome pf 1☐Live birth 2 4☐Pregnant at tir 9☐Unknown	Fetal death	3 □Ectopic preg 5 □ Other (spec				23d. Date Mon	e of delivery hth Day Year
P.O.	that the		9 ☐ Unknown Part II. Other significant conditions or	ontributing to death but	not resulting in	the underlying cau	use given in Pa	rt I.	23e. Did to	bacco use contri	bute to the cause of death?
rds	quires n sign uld be	d by	Altheimer	. Dementi	ia						3 Probably 4 Unknown
900	law re as bee 2 sho	plete							24a. Was a		Vere autopsy findings available
<u> </u>	: The	Completed							autop perfor 1∐ Yes	rmed? d	rior to completion of cause of eath? □ Yes 2 □ No
Zit Zit	slcian certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Other:	/	(Check only or		
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sior	endin sath. or: Aff	atio	1 Natural 5 Pending investigation	(Month, Day Y	rear) in	jury M	vvork? 1 ☐ Yes 2	□No			
Division or Vital Records,	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home, far (Specify)	m, street, factory,	office	2	8f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier Check only one)	ysician: To the best of siner: On the basis of each and manner state	xamination and	death occurred at /or investigation, i	t the time, date n my opinion, o	and place, a death occurre	and due to the o	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				License numbe		- 2	29d. Date signed	(Month, Day, Year)
			I fully	NO			>53186	*		novembe	10,2008
	10		30. Name and address of person who o			4	3.	4		2.11	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	nail Rd	501	172 r 62	u 200	214	
	Registr	ar	NOV 12	2008	to the	Contract !	9				

			For State Registrar		State of Ma	aryiand		rtificate of		-	giene Reg. No.	0000	35858
	Dhysisis		1. Decedent's Name (First,	Middle, Last)						2. Date of Dea Month	Day	y Year	3. Time of Death
	Physicia /Medic		SADIE S. TO							NOVEMBE	-	2008	6:15 A ^M
	Examin	er	4a. Facility Name (If not inst		treet and number)				r Location of Deatl	n		County of Death	
			MANOR CARE 1 5. Social Security Number	LARGO 6. Sex	7. Age	e (In yrs. las	t birthday)	If Under 1 Year	ARLBORO If Under 24 Hrs.	8. Date of Birl			hplace (State or Foreign untry)
ı	Funeral Director		579-12-8012 Usual Residence of Decede	1 🗆	M 2 🖾 F 10		Yrs.	Months Days	Hours Min.	AUCUST 2	y, Year) +, 19	907 NC	untry)
	land ow		10a. State 10b. C			10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary -f sh	to	MD PRI	NCE GE	ORGE'S	CAP1	TOL E	HEIGHTS					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g. Cit	tizen of What Co	untry?
	th with		7302 WILLOW	HILL D	R			20743			U	SA	
	ems	Funeral	11. Marital Status	1	2. Was Decedent I Armed Forces?	Ever in U.S.	13. \	Was Decedent of H	lispanic Origin? (S an, Mexican, Pueri	specify Yes or No to Rican, etc.)		14. Race - Ame Black, White	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Itm M-dical Eval., in a rout be retified a once.	þ	1 ☐ Never Married 2 ☐ 3 🕅 Widowed 4 ☐ Div		Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	No		I∐Yes 2∏XNo	Specify:			Specify: BI	ACK
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Ž	should and Mer s marke umatic	욘	19a. Informant's Name/Rel		na Print)		19b. Mailir	na Address (Street	and Number or R	ural Route Numb	er. City o	or Town. State. 2	Zip Code)
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	/Medical Examiner		resulting in death)		Due to (or as					-			
		7	Sequentially list conditions,	b.	Due to (or as			DIOVASCUI	LAR DISEA	SE		-	
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3ec	e law has b	Completed					***			24a. Was auto	an psy ormed?	prior to death?	itopsy findings available completion of cause of
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Ξ	sicia certi irecto	Be c	25. Was case referred to mexaminer? 1 ☐ Yes 2 🔀 No	⊢ −	ospital:	ant 205	P/Outpatio	nt 3 DOA Otl	nor:	ath <i>(Check only c</i> Home 5 ☐ Resi		6 Other (Cas	-14.1
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ion	nding ath. r: Afte e fun	atio	1 Matural 5 □ I 2 □ Accident	Pending nvestigation	(Month, Da	ay, Year)	Injury		rk?]Yes 2□No				
Division of Vital Records,	er deg	Certification: To		Could not be determined	28e. Place of Inj	jury - At hom	ne, farm, str	eet, factory, office		28f. Location (City or To			ural Route Number,
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical			sician: To the best ner: On the basis of and manner st	of examination							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 92008 Thatch Preston Vovember /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 000 114 2000 oama Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6-8-1931 Birthplace (State or Foreign Country) **Funeral X**□ M 2 □ F Months Days Hours 228-32-3385 N.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, If a Medical Examinating the notified at 1¥ Yes 2 □ No N/A Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5014 Goodnow Road Apt H USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2√ No Specify Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Bethlehem Steel 8th grade N/ALaborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental Hirriam Thatch Eula Thatch ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1520 Gleneagle Road Balto, MD 21239 Tometris Thatch-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial XXCremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 11-12-08 Balto, Greenmount 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H MD 21202 Avenue Balto, North 101 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Momona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Physician/Medical attending pt d for use as the JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 2 (2 No 1 □Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, of Vital Records, P.O. the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Division 2

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signatur nd title of certifier 29c. License number ompleted cause of death (Item 23a) (Type, Print) Samarika Hight Britmore crues3 trivel 31. Date filed (Month, Day, Year) 2. Registrar's Signature State **ORIGINAL**

Registrar

		1	For State OF N State Registrar	Ce	rtificate of L		Reg. N		35861
	Physicia	an	1. Decedent's Name (First, Middle, Last) Leonard Thornton				Pr. A	Day Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or	Location of Death		c. County of Death	
i.er			5. Social Security Number 6. Sex 7.	age (In yrs. last birthday)	Baltir If Under 1 Year	nore I If Under 24 Hrs. 8	M D	9 Rirth	place (State or Foreign
	Funeral Director		217-34-8388 1☑M 2□F	69 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yea		place (State or Foreign ntry) cyland
e, Maryland 21215-	/land	-	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary 8a-fsh	ector	Maryland N/A	Daitim			100	Citizen of What Cou	XXYes 2□No
	th with the 23a or 2	Funeral Director	10e. Street and Number 3800 Fordleigh Road		10f. Zip Code 2121	5	Tog.	USA	nury ?
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, if a Modical Exactical must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Armed Force: 1 Never Married 1 Yes, Give Year or Date:]No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Ilspanic Origin? (Speci an, Mexican, Puerto Ri Specify:		Specify:	etc. Lack
	n /2 no "natur	oletec	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	oation during most of working d)	St.	Kind of Business/II ate of I	ndustry Maryland
	filed within 72 Hygiene. other than "na ent, ire ireale	Completed	Elementary/Secondary (0-12) College (1-40 12th grade			Officer			
	permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event, once.	To Be (17. Father's Name (First, Middle, Last) Buster Thornton			18. Mother's Name (Emma Car		len Surname)	
			19a. Informant's Name/Relationship (Type. Print) Rona Melton/ Sister	19b. Maili 47 Ce	ing Address (Street obber La	and Number or Rural	Route Number, Cit More , Ma	ty or Town, State, Z ryland	io Code) 21229
			20a. Method of Disposition 128Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park 20c. Location - City or Town, State Arbutus, Maryland						
			21. Signature of Juneral Service Licensee	5	22. Name and Addre	ess of Facility Cha Sterstown	tman-Ha Road B	rris Fu	neral Home e,Md 2121
68760,	cate be executed Medical Examiner the burial-transit		23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. SCSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS						
			reculting in death)	as a consequence of):		· h	. D.	1.7	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a sunsequence of):					
		Examiner	Due to (or as a consequence of):						
	tificate be executed ig physician and as the burial-transit	edical E							
	certific nding p		IF FEMALE: 23c. If yes, outcome	ne of pregnancy				23d. Date of deli	verv
	the death cert by the attending ached for use a	ed by Physician/N	In the past 12 months? 4 Pregnar	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown				Month Day Year	
	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ven in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown		
	The law re ate has bee page 2 sho	Completed by					24a. Was an autopsy performed	prior to o death?	topsy findings available completion of cause of
	Physician: The la r this certificate had ral director, page 2	Be	25. Was case referred to medical examiner? 1						
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	n: To	1 Yes 2 No Toophia. Tooph						cify)
		icatio	2 Accident investigation		M 1 🗆	Yes 2□No	of Location (Strong	t and Number or Pi	im! Poute Number
		Certification: To	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route N City or Town, State)						Tar rioute Haribon,
	e Hospit 24 hour e Funera letely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the base and mannel	s of examination and/or					
	To th To th comp	Me	29b. Signature and title of certifier		29c. Licens		29d.	Date signed (Monti	n, Day, Year)
			30. Name and address of person who completed cause	30 MD	K E	5-001		10V 6,	2008
	1)		Schonze Del Pa	520 S	inai H	ospital	Ba	Hmor	e ma
	Sta Regist		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	, , , , , , , , , ,	Certificate of L	Death	Reg. No.	2008 35861
Physic	ian	1. Decedent's Name (First, Middle, Last)	0.01			ate of Death	3. Time of Death
/Med	ical	BUCK TE	KRY	4. 65. 7		JOV 7	2008 602AM
Exam	ner	4a. Facility Name (If not institution, give si	YUND MODICIN	100	Location of Death	40.	County of Death
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) If Under 1 Year Months Days	Hours Min. (f	ate of Birth Month, Day, Year)	Birthplace (State or Foreign Country)
Directo		229-40-6914 1x	M 2□F 74	Yrs.	09/	/13/1934	Virginia
ryland ihow		10a. State 10b. County	10c. City	, Town or Location			10d. Inside City Limits
ne Mar 18a-f s	ecto	MD	Balt	imore			1X Yes 2 □ No
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	3550 4th Street		10f. Zip Code 21225		10g. Citiz	ten of What Country? S $_{ullet}A$ $_{ullet}$
er dea items	une		Was Decedent Ever in U.S Armed Forces?	 Was Decedent of History Street If Yes, specify Cuba 	ispanic Origin? (Specify) In, Mexican, Puerto Ricar	res or No- 1 n, etc.)	Race - American Indian, Black, White, etc.
036 urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	1	1 □Yes 2 No	Specify:		Specify: White
5-0	eted	15. Decedent's Educi (Specify only highest grade		16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of working	16b. Kir	nd of Business/Industry
within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired Stocker))	Gro	cerv
Maryland 2. 2 should be filed v and Mental Hygie is marked other t raumatic event, th		17. Father's Name (First, Middle, Last)			18. Mother's Name (Firs	st, Middle, Maiden S	
arylaı should b and Ment s marked umatic e	To Be	Barney Terry			Beth Carnea		
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any light or other traumatic event, the Medical Evancian in the Institute of the Institute		19a. Informant's Name/Relationship (Type Patricia Terry/Date		19b. Mailing Address (Street a		-	• • •
of Health item 27		20a. Method of Disposition	20b. PI	ace of Disposition (Name of emetery, crematory or other place			cation - City or Town, State
Limo		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	movar from State	omy Gifts Registry	11/12/2	2008 Han	over, Maryland
Baltimorr permit. Pages 1 Department of H Important: If ite any Injury or of		21. Signature of Funeral Service Licenses	1	22. Name and Addres	Iniacc		Registry
		23a. Part 1. Enter the disease, or complic	ations that caused the death		lley Drive, g, such as cardiac or res		Approximate
Physician	8 9	shock, or heart failure. List only one Immediate Cause (Final disease or condition		EREBRATE H	PUNEZ NO	=	Interval Between Onset and Death
/Medical		resulting in death)	Due to (or as a consequ	ence of):	U.OPFIC		
		Sequentially list conditions, b.	Due to (or as a consequ	TENSION			
nd nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
60, be exe		resulting in death) Last	Due to (or as a consequ	ence of):			
68760,	Medical	d.				-	
		23b. Was deceder pregnant	c. If yes, outcome of pregnar		v.	2	3d. Date of delivery
O. Bhe dear	Physician/	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 Pregnant at time of de		y		Month Day Year
hat t		Part II. Other significant conditions cont	ributing to death but not resu	Iting in the underlying cause give	en in Part I.	23e. Did tobacco us	se contribute to the cause of death?
rds quires en sign uld be	ed by					1 ☐ Yes 2 ☐] No 3 Probably 4 ☐ Unknown
eco law re las bee	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital R sician: The certificate r rector, page					1	performed? □Yes 2 No	death? 1 □Yes 2√No
or Attending Physician: after death. Director: After this certification by the funeral director, in by the funeral director, in by the funeral director, in the funeral dir	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2 In	ER/Outpatient 3 ☐ DOA Othe	26. Place of Death (Che		[]Other (2 , (1)
on of allng Phys After this funeral dii	n: To	27. Manner of D ath 1 Natural 5 ☐ Pending		28b. Time of lnjury Work	4 Nursing Home y at 28d. I	Describe how injury	
SiOl teath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 □¹	Yes 2□No		
Division of Vital Records, at or Attending Physician: The law requires the reach. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Certification: To	4 Homicide determined	building, etc. (Specify	me, farm, street, factory, office		ocation (Street and City or Town, State)	l Number or Rural Route Number,
Hospital 24 hours Funeral		29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	er: On the basis of examinat	vledge, death occurred at the tin ion and/or investigation, in my o	ne, date and place, and o pinion, death occurred at	lue to the cause(s) the time, date and	and manner as stated. place, and due to the cause(s)
F 7 7 F	1		and manner stated.				
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ho completely filled in by the funeral director, page	Medical	29b Signature and title of certifler		29c. License	e number	29d. Date	e signed (Month, Day, Year)
To the Ho within 24 To the Fu	Medi	29b Signature and title of certifier	ma Pha				
To the Hu within 24 To the Fu Completel	Medi	29b Signature and title of certifler 30. Name and address of person who con	MA PhA pleted cause of death (Item HUACTURA				
j	ate	30. Name and address of person who con A C Y 31. Date filed (Month, Day, Year)	mpleted cause of death (Item HUNCTUSA) 32. Redistrar's Signatu	23a) (Type, Print) Wed 77 Sour	e number 22162 M GRANT		

#31 of per Boune

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November **Physician** 7, 2008 Joseph Timmons /Medical 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12,418 (5)en mil Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 11/13/1935 Maryland Director 219-30-9917 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, it a Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 U.S.A. 7355 E. Furnace Branch Road permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or it any injury or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White <u>ج</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Metal Worker Industrial 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Counenbaugh John Timmons ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Charles St. Apt. C, Brooklys Park, MD 19a. Informant's Name/Relationship (Type. Print) Charles Rios/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Cremation Services 11/12/2008 Hanover, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation Services, LLC 21. Sign f re f Funer vrvice Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumons **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit the death certificate be executed mn or Due to (or as a consequence of): 68760, attending physician for use as the burial Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes Viital Hospital or Attending Physician: After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Hospital: Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) (Specify) 1 Yes 2 No † Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A letely filled in by the fu investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS. G885.11/12/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MorOct. 3 Pay 2008 Year Physician Someth Thamavana 7: 45 P.M /Medical 4a. Facility Name (If not institution, give street and number)

Manor Care Rossville 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Rosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, October 3, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 XM 2□ F Months 217-94-6672 58 Director Laos Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Overlea 1 □Yes 2√2√No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or United States 21206 525 St. Patrick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Asian Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify 2 3 Widowed 4 Divorced Completed hanavong, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other tran "na any injury or other traumatic event and once." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Construction Worker Asbestos Removal Co. 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Chan Syvongay Be Chaim Syvongay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kham Thamavong 525 St. Patrick Road, Overlea, Maryland 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 180 FOREST HIL Evans Funeral Charl 21. Signature of Funeral Service Ligensee Evans Tureral offacel & Cremation Services - Bel Air 103 cam 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit O B Due to (or as a consequence of) P.O. Box 68760. physician death certificate be Physician/Medical the attending IF FEMALE nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 0 Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Mo Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 👺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number completed cause of death (Item 23a) (Type, Print) D0060560 30. Name and add Name and address of person who BALTIMORE, MG-2124 # 109 -INFOR 201 BACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

onn Leroy Tay		State of Maryland / De 1-For State Registrar	Certificate of Death	and Mental Hyg		a. No. 200	0 0 0 0 0
Physici Medical Exam	an/	1. Decedent's Name (First, Middle,Last) LE ROY JOHN TAYLOR	n Taylor Jr.		Date of Death Month	Day Year	3. Time of Death 0720 hrs
Todioa: Exam		4a. Facility Name (if not institution, give street and number)		n, or Location of Death	Vovember	7, 2008 4c. County of Deat	
F. J. J.		University Hospital 5. Social Security Number 6. Sex 7. Age (In yr	Baltimor		Data of Digit	www.managed.c.B	(2)
Funeral Director		213-84-1982 1XM 2 F 45	rs. last birthday) If Under 1 Months Yrs.	Year If Under 24Hrs. Days Hours Min.	09/08	(MM/DD/YYYY) 9. Bi Forei /1963	
any		Usual Residence of Decedent 10a. State 10b. County 10c. County	City, Town or Location				10d. Inside City Limits
*	٦	MD ANNE ARUNDEL E	PASADENA				1 X Yes 2 No
th the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number	10f. Zip Co		10	g. Citizen of What Cou	intry?
with th 18 23a (7907 WELLESLEY COURT 11. Marital Status 12. Was Decedent Ever in	n U.S. 13. Was Decedent of	122 of Hispanic Origin? (Spec		USA 14. Race - Ame	ican Indian, Black,
death or iten	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X N	lo	uban, Mexican, Puerto Rio	can, etc.)	White, etc.	
us after ural",	à	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed.		No specify:	k done	Specify: BI	ACK
6 172 hou rai "nat cal Exa	letec	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working	g life. DO NOT use retired)		
5-0036 led within 7 Hygiene. other than	Completed	12 17. Father's Name (First, Middle, Last)	SECURIT	Y GUARD 18.Mother's Name (F	int Middle M	SECURI	TY
21215-003 buld be filed within Mental Hygiene. marked other ti	Be C	LEROY JOHN TAYLOR		JOHNNIE		,	
	P	19a. Informant's Name/Relationship (Type, Print)	3.	Street and Number or Rur			e, Zip Code)
ore, MD es I and 2 sho of Health and If iten 27 is		JOHNNIE TAYLOR/MOTHER 20a. Method of Disposition 20	7907 WELL Ob. Place of Disposition (Name of		ASADEN Date	A MD 211 20c. Location - City o	22 r Town, State
More Pages I lent of H int: If it		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or other place) Cedar Hill (Zem 11-18	5-08	Balton, N	10
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr.	Ì	21. Signature of Funeral Service Licensee	22. Name and Ad	dress of Facility JAME		ORTON & SO	NS F.H., INC.
Physician		23a. Aart I. Enter the disease, or complications that caused the de		LAURENS ST. ying, such as cardiac or re		IMORE, MD st, shock, or heart	21217 Approximate Interval
/Medical xaminer		Vailure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wo	ounds				Between Onset and Death
		or condition resulting in death) Due to (or as a consequence	ce of):				
	ner	Sequentially list conditions, if any, leading to immediate cause Enter Underty in Course	ce of):				
/ - 4	xam	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence to the	ce of):				
executed in and il - transit	calE	d. X AMENDED V. a.					
30x 68760, death certificate be exc te attending physician. I for use as the burial -	Medi	200. Il yes, outcome of p	perME,G885,11/	12/08,WS		23d. Date of delive	Ty T
certifica nding ph	cian/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic pregnanc	y	Month	Day Year
Box te death c the atten	Physician/Medical Examiner	1 Yes 2 No 9 Unknown 9 Unknown					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ρ	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying ca	use given in Part I.		2 ✓ No 3 Pro	the cause of death?
of Vital Records, Fing Physician: The law requires the this certificate has been signineral director, page 2 should be	Completed			-	24a. Was a		utopsy findings available completion of cause of
Reco	dwo				autops perform	<u>ned</u> ? death?	
ician:	Be	25. Was case referred to medical examiner?		Other			
ion of Vital tending Physician: eath. for: After this certif	٦.	1 Yes 2 No Impatient 2 27. Manner of Death 28a. Date of Injury	✓ ER/Outpatient 3 DOA 28b. Time of Injury 28c			Residence 6 Other	er:
ion (trendin leath. A tor: A	ation	1 Natural 5 Pending Nov 7, 2008 Accident Investigation	0519 hrs ₁	Yes 2 ✔ No	ubject shot		
Division pital or Attendious after death. eral Director: Affilled in by the fi	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - A	At home, farm, street, factory, of		or Town, St	ate)	ural Route Number, City
Hospit 24 hour Funera		4 V Homicide determined (Specify) Local St 29a. Certifier (Check only) Certifying Physician: To the best of my know					le Av, Baltimore, MD
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or investigation, in my op	inion, death occurred at th		ind place, and due to t	he cause(s)
	2	29b. Signature and title of certifier		cense number		29d. Date signed (M November 8, 20	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	}	30. Name and address of person who completed cause of death (i					
7		Ling Li, MD Assistant Medical Examiner 1		ore, MD 21201			
S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Sign NOV 1 2 2003		P			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State of Marylan 1 - State Registrar		rtificate of De			ne.200	8 35865		
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Marco Teodoro				2. Date of Death Month	Day Ye	3. Time of Death 008 11:45P M		
1.	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death	Novembe	4c. County of [
*	Examini	51	1623 Howard Avenue		Essex			Balti			
	Funeral Director		5. Social Security Number 6. Sex 1 2 19 − 50 − 3416 6. Sex 60	la <i>st birthd</i> ay) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Ye 7 – 11 – 1	9.	Birthplace (State or Foreign Country) MD		
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Loc	cation				10d. Inside City Limits		
	e Mary	ctor	MD Baltimore Es	sex	10f. Zip Code				1 □Wes 2 □ No		
	th with th	Funeral Director	10e. Street and Number 1623 Howard Avenue	U	. Citizen of Wha	t Country?					
15-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Exprimer must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ № 2 2 □ No If Yes, Give Year or Dates: Viet		Was Decedent of Hisp fYes, specify Cuban, I □Yes 2 ☎No 3	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White		
- - - -	I within 72 ho jiene. r than "natur thy Mydical!	Completed	15. Decedent's Education (Specify only highest grade completed)	I (Give i	dent's Usual Occupation kind of work done durn DO NOT use retired)	on ing most of workir	ng 16	b. Kind of Busin	ess/Industry		
7 7	filed within Hygiene. other than '	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Car		aintena		onstru	ction		
Maryland 2	ed dala) Be	17. Father's Name (First, Middle, Last) Unknown			в. мотегs Name Unknown	(First, Middle, Ma	den Surname)			
ary	12 should th and Mer 7 is marke traumatic	으	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and						
ള ത്	s 1 and 2 if Health item 27 i		Donna Teodoro - Wife		Howard A				y or Town, State		
Baltimore,	e = 5		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	yview	sition (Name of natory or other place) Cremato:	ry 11-1	3-08 B	altimo	ore, MD		
Rail	permit. Pag Departmen Important: any Injury once.		21. Signature of Euneral Service Licensee	P	A. 2134	Willow	Spring	Road,	uneral Home, 21222		
	Physician	() is	resulting in death)	h. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arres	,	Approximate Interval Between Onset and Death		
	/Medical Examiner		Due to (or 15 a conseq	months							
	ed sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury								
o,	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last C Due to (or as a conseq								
98760	cate be	dical	d								
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 6 9 □ Unknown			23d. Date of Month					
ds, P.	w requires that the described signed by the should be detached	by	Part II. Other significant conditions contributing to death but not res Chronic Obstructive pulm	sulting in the ur			23e. Did toba		ute to the cause of death? ☐ Probably 4 ☐ Unknown		
Vital Records,	sician: The law req certificate has beel irector, page 2 shou	Completed					24a. Was an autopsy performe	24b. We pric d? dea	re autopsy findings available or to completion of cause of the th?		
/ita		Be C	25. Was case referred to medical examiner?				(Check only one)				
	Physi er this c eral dire	ို	1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	28b. Time of	f 28c. Injury a	4 LI Nursing Hol	me 5X Residence 28d. Describe how		(Specify)		
ion	Attending Ph death. ctor: After th y the funeral	ation	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury		s 2□No					
Division of	after de la Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office	Į.	28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knick one) 1 Medical Examiner: On the basis of examinand manner stated.	owledge, deatl ation and/or in	h occurred at the time evestigation, in my opin	, date and place, nion, death occurr	and due to the cau red at the time, dat	ise(s) and manr e and place, and	ner as stated. d due to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier Muchael II - House	M.D.	29c. License r				Month, Day, Year)		
	871		30. Name and address of person who completed cause of death (Itel Wang Will 4, Levice 6569 No.	m 23a) (Type,	Print) Charles S	4. Suit	1205	Tonson	nleel 11, 2008 n, Maryland 22		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signary	ature	orth				,		

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avise L. Thom		State of Maryland / Department of Health and Mer									
	R	For State Certificate of Death	Reg. No.	2 13: Time of Death J							
Physicia	LUZ	. Decedent's Name (First, Middle,Last)	Month Day October 31, 2008								
edical Exami		ALTAVISE L. THOMPSON Facility Name (if not incitiviting, give street and number) 4b. City, Town, or Location		County of Death							
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County or 4d. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County or 4d. Facility Name (if not institution, give street and number) 4c. County or 4d. Facility Name (if not institution, give street and number)									
			er 24Hrs. 8. Date of Birth(MM/D	D/YYYY) 9. Birthplace (State or							
Funeral Director	-	Months Days Hour	s Min. 11-3-19	Foreign Country) PENNA							
Director	L	1,7,5,7,7,7,7,7,7,7,7,7,7,7,7,7,7,7,7,7,	11 3 17	, 0							
any.		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
3		PENNA DAUPHIN HARRISBURG		1 X Yes 2 No							
taryland 28a-f show 1 at once.	후	10e, Street and Number	10g. Citiz	en of What Country?							
Mar r 28a	Director	203 HUMMEL ST. APT 2 17104	Į	JSA							
th the		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	rigin? (Specify Yes or No-	14. Race - American Indian, Black,							
ith wi fems st be		1 YNover Married 2 Married Armed Forces? If Yes, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.							
er dez , or i		1 Yes 2 X No specification of the second of	у:	Specify: AFRICAN-AMER							
rs aft nral"	b A	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giv		ind of Business/Industry							
2 hou "nat	<u>ş</u>	Flementary/Secondary (0-12) College (1-4 or 5+)		IDVEN HILI							
)36 hin 7 than than	힐	-10- CASHIER		JRKEY HILL							
5-0036 Ited within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	er's Name (First, Middle, Maiden	Surname)							
215 ve file ntal H ked o	Be (JUHAN THOM BOX	IANA PURNELL	7: 0-4:)							
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygies and "I fitem 27 is marked other than "natural", or items 23a or 28a-f sho rother trannatic event, the Medical Examiner must be notified at once.	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N									
MD rd 2 sho ulth and m 27 is		DICEDUAL	T HARRISBURG	G PENNA 17104 Location - City or Town, State							
ore, MC es 1 and 2 s of Health au If item 27		20a. Method of Disposition Windows and Disposition (Name of cemetery, crematory or other place) Windows and Disposition (Name of cemetery, crematory or other place)									
nor Pages ant of int: 11		EVANS CREMATION		SHAFFERSTOWN, PA							
		21. Signature of Frincial Service/Licensee NAZHAND, HI 22 Narge and Address of Fac	HityMAJOR WINFI	ELD FUNERAL HOME							
Balt permit Departi Import		704 N FRON	T ST. STEELT	ON. PA 1/113							
Physician		23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	s cardiac or respiratory arrest, sho								
"Medical	l l	Imme_late Cause (Final disease a. Hemopericardium		Death							
aminer		or condition resulting in death) Due to (or as a consequence of):									
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exec		UNPENDED AMENDED									
Box 68760, e death certificate be exe the attending physician and for use as the burial -	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		d. Date of delivery Month Day Year							
387 rtifica ling p	an/I	nast 12 months?	opic pregnancy	Month Day Year							
Sox 687 leath certific e attending I	Sici	Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown g Unknown									
he de	چ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23e. Did tobacco	use contribute to the cause of death?							
, P.O. B res that the d signed by the detached		Hypertension; Diabetes	1 Yes 2	No 3 Probably 4 ✔ Unknown							
S, F uires n sign	pe	Hypertension, Diabetes	24a. Was an	24b. Were autopsy findings available							
ord wreq	l e	Morbid Obesity	autopsy performed?								
ecc he la ate ha	Completed by		1 ✓ Yes 2	No 1 Yes 2 No							
E T. T. T. T. T. T. T. T. T. T. T. T. T.	BeC	25. Was case referred to medical	ath (Check only one)								
Vita ysicia his ce	e	examiner? 1 V yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other		lence 6 Other:							
Of of right Ph	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at V		jury occurred							
OD tendii	i	Natural 5 Pending		and Number of Dural Davis Number City							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and a control of the house as the burial - trails.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building	g, etc. 28f. Location (Street or Town, State)	and Number or Rural Route Number, City							
Divis To the Hospital or A within 24 bours after To the Funeral Diversional Divisional Collection in the contraction of the co	ert	4 Homicide determined (Specify)									
Hosp 24 ho Fund		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an	d place, and due to the cause(s) a	and manner as stated.							
To the Hos within 24 h	Medical	one 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, deal and manner stated.		I. Date signed (Month, Day, Year)							
F % F 8	<u>`</u> ≥	29b. Signature and title of certifier	1								
		O.C.M.E.	No	ovember 3, 2008							
		30. Name and address of person who completed cause of death (Item 23a)									
1	1	Laren Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201								

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

NOV 12.

32 Begistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 11-05-2008 1914 Anna Mary Vespucci /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 05-15-1926 MD 220-18-8490 82 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examination of the 1 ☐ Yes 2 No Director MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1000 Wingate Ct 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21245-0036 1 □Yes 21☑No If Yes, Give Year or Dates Specify: Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiene. Furniture Company Bookeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Schiminger Clement Hunt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S JoAnne Kehoe 1000 Wingate Ct Bel Air, MD 21014 other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 of Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 11-08-2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a ceach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed physician and the transit resulting in death) Last Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. TYPS 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Son of Vital Records þ 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 s has certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2V No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 2 this funeral 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

00

ess of person who completed cause of death (Item 23a) (Type Print)

29c. License number

29d. Date signed Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend istante of the aryline 885 partinent of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Paula Theresa Vannoy 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

	Physician /Medical Examiner
-	Funeral

Director 28a-f show Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Department of Health and Mental Hygiv Important: If item 27 is marked other any injury or other traumatic event, It once.

Director

Funeral

þ

Completed

Be

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

Physician /Medical Examiner

Baltimore, Maryland

P.0. Records, After this certificate Division of Vital

24 hours after death Funeral Director: within 2 To the I 3

Square Franklin HOSpital 05 Pi + a | ROSe dale 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. more 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F Months Days Hours Min 213-70-1206 07/19/1967 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 Elmont Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental_Hygenist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Lewis Ruth Geary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Cruse/Sister 9115 Summer Park Dr., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ardent Cremation Services 11/12/2008 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Co 22. Name and Address of Facility Ardent Cremation Services, LLC 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AnoxiL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Abnormalities Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4
Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature an le of certifie H0025054 11. 7 2008

DHMH 17 Rev 1/2001

1 /Ter 9000 Franklin Square Drive Baltimore, MD 2/237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rames

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	r Marylar	•	artment of rtificate of		Mental Hyg	iene eg. No. 2 (108	358	69
	Physicia	an	1. Decedent's Name		•					2. Date of Death Month	Day	Year	3. Time of De	
-	/Medic		Philippe Vauthier 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							November	1		3:50	A ^M
	Examin	er	Genesis E					Annapol		ın		y of Death Arun	lel	
rides	Euroval	c	5. Social Security N		7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24 Hrs	8. Date of Birth			lace (State or F	Foreign	
	Funeral Director		055-50-71	.89	1 □ M 2 🗶 F	72	Yrs.	Months Day	s Hours Min	8. Date of Birth (Month, Day, APR 7,	1936	Switz	zerland	
	how how		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	cation				11	0d. Inside City	
	e Ma 3a-f s	cto		Anne Ar	ındel	Ann	apolis						1 ☐ Yes 2	™ No
	or 2	Dire	10e. Street and Nur					10f. Zip Code			0g. Citizen of		try?	
	s 23a	eral	612 Third	St	10 W . D.	In a Francis III	0 40	21403	t Historia Osisia O		witzer		an Indian	
36	be filed within 72 hours after death with the Maryland ttal Hyglene. do other than "natural", or items 23a or 28a-f show event, I've Medical Eventiner must be notified at	by Funeral Director	11. Marital Status1 □ Never Marri3 □ Widowed	ied 2 X Married	Armed For 1 □ Yes If Yes, Giv	/e		was Decedent o If Yes, specify Cu 1 □ Yes 2 🛣 N	f Hispanic Origin? (uban, Mexican, Puel lo <i>Sp</i> ec <i>ify:</i>	rto Rican, etc.)	Bla	ice - Americ ack, White, e ^{'fy:} Whit	etc.	
2-00	72 hour natural	eted b		15. Decedent's	Year or Da Education urade completed)	ates:	16a. Dece	dent's Usual Occ	cupation ne during most of wo	orkina i	16b. Kind of E			-
2121	within jiene.	Completed	Elementary/Seco		College (1 5 +	-4or 5+)	Inven	DO NOT use reti	red)		lenewah	le En	ergy	
b	al Hygi other	Be C	17. Father's Name	(First, Middle, La	st)				18. Mother's Na	ame (First, Middle, M				
/lar	should be nd Mental marked c	10 E	Firmin Va	uthier					Sarah So	chupart				
lar)	a is a		19a. Informant's N				1	,		Rural Route Number	•	n, State, Zip	Code)	
≥,	1 and 2 Health em 27 other tr		Denise Va		wite		- 1			, MD 2140		O:1	01-4-	
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Hea Important: If Item 2 any injury or other QDCE.				Removal from s	State Me	cemetery, crei tro Cr	esition (Name of matory or other p ematory	Inc 11/		20c. Location Baltim	•		
Balt	permit. Departr Imports any inju		21. Signature of Fu	uneral Service Lic	ensee C. To	odd Dri	ng g	2. Name and Add	dress of Facility Society	of Maryla Baltimore	and, I	nc.		
	Physician	8 7 ₁	23a. Part1. Enter t shock, or hea Immediate Cause disease or condition	ırt failure. List on (Final	mplications that coly one cause on e	aused the dea ach line.	th. Do not en	ter the mode of o	lying, such as cardia	ac or respiratory arre	est,	1.2.20	Approximate Interval Betwe Onset and De	ath
	/Medical Examiner		resulting in death)	1	Due to (or as a consec								
	₽ ⊭	iner	Sequentially list co	innectrate erlying	b. — Due to (or as a conse	uence of:							
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	or as a consec	quence of):									
68760,	cate be ohysicia the buri	edical			d									
Box 6			IF FEMALE: 23b. Was deceden		23c. If yes, out	come of pregn		⊒ Ectopic pregna	ancy		23d. Date of delivery			
O.	law requires that the death cer as been signed by the attendir 2 should be detached for use	Physician/M	in the past 12 1 ☐ Yes 2[9 ☐ Unknown	No		nant at time of		Other (specify)			N	onth	Day Ye	ar
S, P.	w requires that the de been signed by the should be detached		Part II. Other signi	ficant conditions	s contributing to de	eath but not res	sulting in the u	nderlying cause	given in Part I.				ne cause of dea	
ord	requir een s rould	ted								. 1	s 2 2+40	3∐ Proc	ably 4 🗋 Un	Known
Records,	The law ate has b	Completed by								24a. Was ar autops perform	у	. Were auto prior to con death? 1 Yes	psy findings av mpletion of cau	ailable use of
ita	stan: ertifica etor, p	Be C	25. Was case refer examiner?	red to medical					26. Place of De	eath (Check only on				
) t	Physician: r this certific ral director,	70	1 ☐ Yes 2 2		Hospital: 1 □ I	Inpatient 2 □	ER/Outpatie	nt 3 DOA		Home 5 ☐ Reside	ence 6 🗆 O	ther (Specif	y)	
ion o	Attending P ir death. ector: After t by the funera	ation:	27. Manner of Deat 1. Natural 2 Accident	th 5		of Injury th, Day, Year)	28b. Time o Injury	W	njury at ⁽ √ork? □Yes 2 □No	28d. Describe ho	w injury occu	irred		
Division of Vital	To the Hospital or Attending Physician: The In within 24 but and the form after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification:	3 Suicide 4 Homicide	6	be 28e. Place buildi	of Injury - At h	ome, farm, sti	eet, factory, offic	e	28f. Location (St City or Town		nber or Rura	al Route Numbe	er,
	Hospital or 24 hours afte Funeral Dir stely filled in	Medical C	29a. Certifier (Check only one)	Certifying Medical Ex	aminer: On the b	best of my kn asis of examin ner stated.	owledge, deat ation and/or ir	h occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and rate and place	manner as s e, and due to	stated. the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and	title of certifier)	12		29c. Lice	ense number	36 2	9d. Date sign	ed (Month,	Day, Year)	
	in	1	30. Name and ad	ress of per on w	completed caus	se of death (Ite	m 23a) (Type,	Print)		36 ² e cho	11/	112	008	
	\U Sta	te.	31. Date filed (Mon	hh, Day, Year)	2000 32/B	egistrar's Sign	LUB ature	Dr Dan	p Bru	e Cho	o he	N)	2161	7
	Registr			MATZ	ZUUÖ Z	Estated a	D. A							

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death.

filled in by

W W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 51705

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 11-05-08

ANSU RIVA malculm 31. Date filed (Month, Day, Year) NOV 12

DR, Westminster, mn 21157

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 358 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WISE **Physician** HOM AS 2009 /Medical of Death Facility Name (If not institution, give street and number Town or Location of Death Examiner Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Social Security Number Funeral Min. Months Days Hours Yrs. 25 Washington Do Director Usual Residence of Deced State 10b County 10c. City, Town or Location 10d. Inside City Limits 10а ns 23a or 28a-f show must be notified at 1 □Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Completed by Funeral 12. Was Decedent Ever n U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 Tes 2 No f Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 'natural' Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) econdary (0-12) College (1-4or 5+) Transportation Supervisor Juvenile

18. Mother's Name (First, Middle, Maideg Surname) 0 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship Type. Print) (W He 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) inesville 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service Ligensee 7 atelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OMPLICATIONS DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are, but in your content of the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offi To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page 2 2 No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ..
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

BABATUMDE 31. Date filed (Month, Day, Year)



M)

PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

DOO 6 4533 LEVINDALE - HEISKIN

W. BELVEDERE

03/2008

ENTIMENT

Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7,2008 11:28PM George Joseph Weitzel Sr. November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins - Bayview Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day 7 (Annum 17, 1927) March 17, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) Months Days Hours Min. 1 1 XM 2 □ F 217-22-9947 81 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1829 Walnut Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Self-employed Star Graphix Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William G. Weitzel Dorothy Flury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane A. Weitzel wife 1829 Walnut Avenue, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Novelfiber 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 13, 2008 Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Dinnelly Funeral Home Of 10 Sollers Point Road, ure of Fundral Service License 23a. Part 1. Enter the disease, o complications that caused the de ... Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical **Examiner**

certificate be executed

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f shov

Director

by Funeral

Completed

Be

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Modical Exaction in mist be notified at

12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trains

within 72 hours after death

Baltimore, Maryland 21215-0036

Physician/Medical Examine the burial-trar attending physician for use as the burial as signed by the a I be detached f Þ Completed by cate has t Medical Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

disease or condition resulting in death)	a. Due to (or as a consequence of): Chromi renol failu	3	Oliset and Dealif				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	ч.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year				
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. Plus Mellitus. Plust vascular disease.		use contribute to the cause of death?				
per	shoul vascular diseas	24a. Was an autopsy performed?					
25. Was case referred to medical	26. Place of De	ath (Check only one)					
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	Home 5 Residence	6 ☐Other (Specify)				
27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred				
1		of be led 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)					

29d. Date signed (Month, Day, Year)

11/10/03

adelphro Rel Suite (08 Balt Md2,23)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** a M 6:00 /Medical Alice L. Williams 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 925 N. Broadway Baltimore
If Under 1 Year | If Under 24 Hrs. Apt 411 N/A Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2-8-1933 5. Social Security Number 219–26–4236 **Funeral** 1 M 2 XF Months Days Hours Min. 75 Director N.C. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Wedical Examirer must be notified a once. 1√Yes 2 No Director MD N/A Baltimore 10e. Street and Number 925 N. Broadway 10f. Zip Code 10g. Citizen of What Country? Apt 411 21205 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2√☐No Specify: Black \$ Snecify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes N/A Domestic Worker N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Alexander Jessie Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collins 5408 Sinclair Greens Drive Balto, MD 21206 Kenneth 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Zion Cemetery 11-14-08 20a Method of Disposition 20c. Location - City or Town, State 1XXurial 2 ☐ Cremation 3 ☐ Removal from State Lansdown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fusional Service Licensee 22. Name and Address of Facility March East F/H Avenue Balto, 1101 E. North MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Example 10 June 10 Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the 1 ☐ Yes 2 ☐ No. 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2VZ No 1 ☐Yes No 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 15 Residence 6 Other (Specify) 1 Yes 2√No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Treet #308 Baltimore MD2120 N. Eutaw 821 31 Date filed (Month, Day, Year) 32 Registrar's Signature

State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 Month P619 2008 12:10 **Physician** Alice C. Wiedorfer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5 Social Security Number 7 Age (In vrs. last birthday 05/19/1920 Year) **Funeral** 1 □ M 2 👿 F Maryland 88 Director 217-16-6519 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 X No Director Baltimore MD Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21234 U.S.A. 2506 Moore Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Czerwinski Alfred Stauffer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3210 Chesley Avenue, Baltimore, MD 21234 Randee M. Fyfe, Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 11/13/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Derand 5305 Harford Road, Baltimore, MD 21214 ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months?
1 □ Yes 2 □ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 7 nknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 You page 2 s 1 □Yes 2 12100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi signed by the a has certificate this funeral al or Attending F after death. After illed in by the f To the Hospital 124 hours a within 24

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

31. Date filed (Month, Day, Year)

29b. Signature and title of centifier

29a, Certifier

Medical

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated.

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

_isa	a Willis		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2008 351
Me	Physicia dical Exami		MOIII Day 169 0400
1			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			915 McAleer Court Baltimore N / A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
	Funeral Director		212-86-9637 1 M 2XF 35 Yrs. Months Days Hours Min. Sept. 29, 197 Foreign Country) MD
	any .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin
	Maryland 28a-f show any <u>d at once,</u>	'n	MD N/A Baltimore 1XXves 2
1	the Maryla a or 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 913 McAleer Court 21202 USA
200	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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	215-0036 be filed within 7 ntal Hygiene, rked other than ent, the Medica	Be Cor	
	MD 2121 nd 2 should be fil alth and Mental F m 27 is marked aumatic event,	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	is I and 2 s' of Health an If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
	Baltimore, permit. Pages I an Department of Hea Important: If iten		Greenmount Cemetery 11/8/08 Baltimore, MD
	Baltimo permit. Page Department Important: injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Ho 4210 Belair Road Baltimore, MD 21206
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Inter
	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive cardiovascular disease Due to (or as a consequence of):
			Sequentially list conditions,
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
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	50, te be executed ysician and burial - transit	edical	X UNPENDED 23a,PII,27,perME g885 11/24/08 TT
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	
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	S, P. uires th	ed by	Obesity 1 Yes 2 No 3 Probably 4 V Unknow
	Division of Vital Records pital or Attending Physician: The law requirents after death. In a Director: After this certificate has been filled in by the funeral director, page 2 should	Completed	24a. Was an autopsy findings availate autop
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	Yit Physici r this o	To B	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Wirsing Home 5 Residence 6 Other: Scene
	n of iding Ph. h. After a funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occu
	isio Atten er deat rector	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street and Number or Rural Route Number, Control of Street Andrews Number or Rural Route Number, Control of Street Andrews Number or Rural Route Number, Control of Street Andrews Number or Rural Route Number, Control of Street Andrews Number or Rural Route Number or Ru
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	Division To the Hospital or Attent within 24 hours after death To the Functal Director:	Medical C	
	To wit	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			0.C.M.E. November 6, 2008
			30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
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			Registrar 1. Decedent's Name (First, Middle), Last)		Cei	lineate of	Dealli	2. Date of De	Reg. No.	UUC	3. Time of Death	
	Physicia /Medic			Ennis	s Lo	uise	Wood		Month ()	Day	Year 2008	3 23 15 pm	
	Examin		4a. Facility Name (If not institution					r Location of Death			nty of Deat		
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits	
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	vith the	Directo	10e. Street and Number 2900 Dunbrin	Dond Ant 1	^	_	10f. Zip Code			10g. Citizen	of What Co	untry?	
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9	after d	/ Fur	1 ☐ Never Married 2 ☐ Marr	Armed Forces?	•		fYes, specify Cub I∐Yes 2√∑No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White		
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Mydleal Eventing must be notified at	ed by	3₺ Widowed 4 Divorced	Year or Dates:	16	6a. Decedent's Usual Occupation				16b. Kind o	cify:	White	
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and	d be fill ental F ced otl	Be c	17. Father's Name (First, Middle, Harley Fre					18. Mother's Name	die E.		,		
Maryland	shoul and Mark s mark	2	19a. Informant's Name/Relations					and Number or Run				Zip Code)	
	and 2 lealth m 27 I		Rita Bennett	(Daughter)				re Road				21222	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition P Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 Removal from State	cemet	tery, cřen	sition <i>(Name of</i> natory or other pla emetery	ce) 11/10/:	Date	20c. Location	ille,		
alti	mit. P partme portan / injur		21. Significant Puneral Service	1211	DISI	22	Name and Addre	ess of Facility	-				
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		8 11	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each li	d the death. Do	o not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as	remic a consequence								
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P.O. Box 6876	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of deli	ivery	
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≥ O	al or Attend s after death il Director: v d in by the f	Certification:	4 ☐ Homicide determ	ned building, et	c. (Specify)	iaiii, sire	eet, factory, office		City or To	wn, State)	mber or Hu	ıral Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.		(Check only 2 Medical	g Physician: To the best Examiner: On the basis of	of examination a	ge, death	occurred at the ti	me, date and place,	and due to the	cause(s) and	I manner as	s stated. to the cause(s)	
	o the vithin 2 o the	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	se number		29d. Date sig	ned (Month	h, Day, Year)	
	->		1	m	2 -			5473	6	11-	4-2	008	
	5		30. Name and address of person										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#12, perFH, G885, 1/12/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 6 45 MM FRADY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ha- Ford 74.11 2613 74,11 Rock FURSA Chestnut If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) JEORGIA 5. Social Security Number 8. Date of Birth (Month, Day, Year) 3 3 1919 **Funeral** Months Days Hours Min. 253-12-3076 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evan, increases the notified at MID 1 ☐ Yes 2 No **Funeral Director** HARFORD MEST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Be Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) YOR 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nthonu 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cemation 3 ☐ Removal from State Department of Fineral Chapol-Belfir 11/11
22. Name and oddress of Facility & New FOREST 108 4 □ Donation 5 □ Other (Specify) 111 21. Signature of Funeral Service Gicenses NEMATION SERVICE MD DIOSO inverty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CUA weeks /Medical Due to (or as a consequence of): Examiner 4+315 RSCUD Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): executed and burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð hypotemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed a trick 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? page 2 CAEUMONIL 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐Yes 2 ☐ No 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D3/295 11/10/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 Balhonne 21206 Kenwich see KIUPSZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 213P M Wimer November 04, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Upland Pikesville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9 23 1921 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F 218.46.1195 Director Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or rother traumatic event, I'm Medical Exertine cast be nothing at any Injury or their traumatic event, I'm Medical Exertine cast be nothing at Director Balti more 1 ☐ Yes 2 XNo PIKESVIlle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Upland 21208 USA Koad by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Koger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upland Road Pikesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pikesville, MD Ridge 07/08 Druid 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 8728 Liberty Road Kandallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart hillure. List only one cause on each line. Immediate Cause (Final **Physician** cerebral Vascular week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ves 2 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\sum \) Nursing Home 1 Yes 2 No မ 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Records, P.O. Box 68760. Division of Vital within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Ellen RFarrell



3250

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INSCRNP

0866

ting Gate

Woodbinema

Amend 16a, perFH G885 11/12/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan	•	iment of Hea ficate of Dea		-	N2008	35879
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1	/Medio		Mayd B. W 4a. Facility Name (If not institution, give	street and number)	4	b. City, Town, or Loca		November	4c. County of Death	
1	Examili	ei	Manor Care - Dul			Timoni			Baltim	
	Funeral Director		5. Social Security Number 6. S 212 • 01 • 4921 1			f Under 1 Year If L	Jnder 24 Hrs. 8. ours Min.	Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
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	e Mary 3a-f sh uiried	ctor	MD Balti	nove 1	Kandal	Istown				1 Tes 2 No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 10 Jolie Court	į		10f. Zip Code 2113	33	10g.	Citizen of What Cou	ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Medical Eventinar must be notified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		s Decedent of Hispares, specify Cuban, Mi	nic Origin? (Speciti exican, Puerto Ric pecify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: Bl	
21215-0036	ithin 72 ho ne. han "natu e Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give kin life. DO	it's Usual Occupation of of work done during NOT use retired) **Domest	g most of working		. Kind of Business/Ir	
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altimore,	permit. Pages 1 Department of F Important: If ite any injury or ot		20a. Method of Disposition 1	Bq	Himore	on (Name of ory or other place) National	11/13/	08 B	altimore	MD
Bal	permi Depar Impor any ir once.	e (8	21. Signature of Funeral Service Licen	y .	22. N	lame and Address of 28 Liberty	Road R	andalist	own MD	21133
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)		n. Do not enter		ich as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
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	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):					
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			30. Name and address of person who	IN NI	Cutar st	net Ba	865 actimos	e m	q 21	201
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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rylan show	_	10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits	
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with the	<u></u>	10e. Street and Num					10f. Zip (izen of What Co	ountry?	
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or ite			ed 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give			If Yes, specit 1 ☐ Yes 2:		xican, Puerto ec <i>ify:</i>	Hican, etc.)		Black, Whit	e, etc. LACK	
should be filed within 72 hours after death with the Maryland and Mental hygiene. I warked other than "natural", or items 23a or 28a-f show umatic event, the Madical Examinar must be notified at	d by	3 ☐ Widowed		Year or Dates:								орссну.		
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\		30. Name and addr	ess of person who	completed cause of	death (Item	23a) (Type,	Print)	10 P	A					1 5
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 03,03RM 2008 ean 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban / tego rel, 8600 Old Georges
Social Security Number 6. Sex 7. Age (In yrs. last birthday) enan Ry Bothesde day) If Under 1 Year If Under 24 Hrs. Bethesde Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Year Months 1 M 2 KF 78-22-615 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Evanting out the rediffical and a summatic event, the Madical Evanting out the rediffical and the same of the same o 10a. State 10b. County 1 ☐Yes 2¶ No Director Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 **USA** 199 Rollins Avenue, Apt 826 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 White 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Marie Benowitz George A. Keyser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. Robert Wayne Weeks-Son 9597 Deadfall Road, Brighton, TN 38011 20b. Place of Disposition (Name of cemetery, crematory or other place)
Funeral Choices
of Chantilly 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4☐Donation 5 ☐Other (Specify) 11-10-08 Chantilly, VA 21. Signature of F 22. Name and Address of Facility 14522L Lee Road M00968 Funeral Choices of Chantilly Chantilly, VA20151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (at as a consequence of): Examiner neumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physician are the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p I be detached for use as t IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has er this certificate has performe 2 DiNo 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 MNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred opital or At.
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completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 043443 MO and address of person who completed cause of death (Item 23a) (Type, Print) 860001d Cocongern Rosl, Bethosda, MB 20814 ohni less 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **6**, Month **Physician** 2008 6:44 РМ November Elizabeth Marie Walsh /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Hospice Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) April 12, 1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 84 118-18-5589 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director New Jersey Union Scotch Plains 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or ury or other traumatic event, Ite Medical Equipment must be usy or other traumatic event, Ite Medical Equipment must be 2079 Arrowwood Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No White Specify. Specify: à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide 12 Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Edward Whelan Marie Agnus Norris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2881 Franklin Oaks Drive, Herndon, Virginia 20171 Lisa Tyler /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 10, 2008 Westfield, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Ma
23a. Part 1. Extendine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Small Bowel Obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anoxic Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ĭ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \bowtie$ Other (Specify) Hospice1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Kenertehon DOO 6374 X November 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Jocelyne T. Kouatchou, M.D. 31. Date filed (Month, Day, Year) NOV 1 2 32 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1 - State Registrar			Certificate of	Death		Reg. No.	108	35884
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

onn William Ar		1- For State Registrar	ite of Maryland		rtificate o			Mental F	R	eg. No.	20	
Physici Medical Exam		1. Decedent's Name (First, Middle John William	Arntz					- y	2. Date of Dea Month October 2	Day	Year	3. Time of Death 2259 hrs
		4a. Facility Name (if not institution University Hospital	, give street and number	7)		4b. City, 1 Baltin		cation of Deat	n ,	4c. Cou	nty of De	ath
Funeral Director		5. Social Security Number	5. Sex 7. A	ge (In yrs. I	ast birthday) Yr	Month	er 1 Year is Days	If Under 24Hr Hours Min	,		YYY) g.	Birthplace (State or Foreign Country) Iaryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City.	, Town or Loca	ition						10d. Inside City Limits
	ž	Maryland Carol	ine		dgely							1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip			1	l0g. Citizen o		ountry?
vith the] s 23a or		11008 Ho11y Ro	ad 12. Was Deceder	t Ever in U	S 113 W		1660	nic Origin? (S	pecify Yes or No	U.S.A		nerican Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygien and "natural", or items 23a or 28a-f She traumatic event, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 Mar	ried Armed Forces		If '	Yes, specif		lexican, Puert			Vhite, etc	
hours a		15. Decedent's Education (Speci						(Give kind of O NOT use re		16b. Kind o	f Busine	ss/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Heath and Mental Hygiene. Tition 27 is marked other than "natural", or other traumatic event, the Medical Examines or other traumatic event,	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	stud	lent				n/a		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, I	,				- 1		e (First, Middle,		ame)	
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If tiren 27 is marked oth injury or other traumatic event, the.	To Be	Michael Arntz, 19a. Informant's Name/Relationsh			19b. Mailir	ng Address			is Arnta Rural Route Nu		Town, St	ate, Zip Code)
MD nd 2 sho ulth and nu 27 is aumati	E F	Jan D. Arntz/	mother	T					Ridgely,			
Baltimore, permit. Pages I an Department of Hea Important: If iter mjury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S	tate '	Place of Dispo crematory or o	ther place)		Date		·	or Town, State
I ltim nit. Pag artment ortant:		4 Donation 5 Other Spe 21. Signature of Funeral Service L		Ri	ldgely	Name and	Address of	Facility				, Maryland
Ba perm Depri		Miss Cl	ly		F. Po	leeg1 Box	e and 160;	Helfer Green	nbein Fu sboro, N	ineral Marylai	Home	PA 1639
Physician /Medical `xaminer		23ấ. Part l. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		Force Inj	uries	the mode	of dying, su	ch as cardiac	or respiratory arı	rest, shock, c	r heart	Approximate Interval Between Onset and Death
	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	seguence o	of):			-				-
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence o	ıf):							
ecuted and transit		events resulting in dealin) Last	d									
O, e be exe sician burial -	Medical	UNPENDED	AMENDED							===		-
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	4 Pregnant a	me of preg	2 F	etal death Other (Spe	3	Ectopic pregn	ancy	23d. Da Mon		very Day Year
ires that the signed by the detacher	by	Part II. Other significant condition	ns contributing to dea	th but not r	esulting in the	underlying	cause give	en in Part I.		obacco use o		to the cause of death? Probably 4 Unknown
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1 of Vit ding Physic After this funeral dire	ı: To	1 Yes 2 No 27. Manner of Death	28a. Date of In	ury	28b. Time of		28c. Injury a	- ING 3	ng Home 5		curred	
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F * F 8	Me	29b. Signature and title of certifier	SIMILEU			290	c. License n				- '	Month, Day, Year)
		and le	My	d = 10 - 200	. 02-)		O.C.M.	⊏.		Octobe	r 28, 20	
-		 Name and address of person v Russell Alexander MD. 	Assistant Medi	,	niner 11	. Au .	Street, B	altimore, M	1D 21201			
S	tate	31. Date filed (Month, Day Year)	908 Registr	ar's Signat	ire							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year GOD M **Physician** CHRISTIAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death aminer BALTINOUE

ar If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) JOHNS BAYNEW MEDICA CEMEN HOPKINS If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□F Yrs 2008 Director Unav Aug. 6, Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Evanisar must be notified at 1 X Yes 2 □ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Ouebec Terrace #2 20903 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Guatemalan þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed wi h and Mental Hygier 7 is marked other th Infant Infant Never Worked Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unavailable Danny Elizabeth Alay Mateo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Danny E. Alay Mateo / Mother 1000 Quebec Terrace #2, Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Cemetery injury 10/23/2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Dasc Janning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician Medical disease or condition resulting in death) XTREME UEKS Due to (or as a consequence of): Examiner ENCEPHALOPATHY HYPOXIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ORGIAN 1 ☐ Yes 2XX No 3 ☐ Probably 4 ☐ Unknown FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate Vital 1 Tyes 2 No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA of this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death. 1 □Yes 2 □No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

State Registrar

Medical

Tauvon M. Gilmore MD 31. Date filed (Month, Day, Year)

(Check only one)

4940 Fastern Ave At2, Baltimore, MD 21224 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D005/186

29d. Date signed (Month, Day, Year) October 20, 2008 **Physician** /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mudical Exercites must be notified at once.

Physician /Medical Examiner Be Completed by Funeral Director

2

	Please							l Copies A	_	ble.	
For State		State of	f Marylar		artment c rtificate d			lental Hygie	£ €	08	3538
Registrar 1. Decedent's Nam	e (First, Middle, L	ast)			incate (JI Deali	,	2. Date of Death	. No.		3. Time of Death
Jack			דת	~~=-				Month .	Day	Year 2008	
4a. Facility Name (i		ive street and nur		gaze	4h. City. Tow	n, or Location		October	4c. County		
Doctors (,		_ `.		roi Dodai				
5. Social Security N			7. Age (In yrs.	last birthday)	Lanha If Under 1 Ye	ear If Unde	er 24 Hrs.	Date of Birth	Prince	9. Birth	place (State or Foreign
075-12-32	293	X M 2 F	90	Yrs.	Months Da	ays Hours		(Month, Day, Y April 17	,		intry)
Usual Residence of									, 1310		York
10a. State	10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Maryland		Georges	48	Hillsid	de Dr.	Greenb	elt				X□Yes 2□No
10e. Street and Nu					10f. Zip Coo	de		10g	. Citizen of \	What Cou	intry?
48 Hillsi	de Dr				2077				S.A.		
11. Marital Status	3.7	Armed Fo		S. 13. \	Was Decedent If Yes, specify (of Hispanic C Cuban, Mexic	rigin? (Spe an, Puerto I	cify Yes or No- Rican, etc.)		e - Ameri ck. White.	ican Indian, etc.
	led 2 Married	If Yes, Giv	/e	1	1 □ Yes 2 🖁	No <i>Specif</i>	y:		Specif	Whi	te
3 Widowed		Year or Da	ates:	100 00000	danda Harris O						
(Spec	15. Decedent's cify only highest g	rade completed)		(Give	dent's Usual Oo kind of work do DO NOT use re	one durina mo	st of workir	ng 16	b. Kind of B	usiness/ir	ndustry
Elementary/Seco	ndary (0-12)	College (1	-4or 5+)			-ui -u i					
17. Father's Name	(First, Middle, La:	st)		Mainta	inance	18. Mot	her's Name	(First, Middle, Ma	MI'RAK	ne)	
Issac Al									idon Carnan	,	
19a. Informant's Na	Ĩ	(Time Drint)		10h Mailin	a Address (Ct			aforta	NA T	04-4- 7	- 0-4-1
Maria Al				1	.llside			I Route Number, C		State, Zi	p Code)
20a. Method of Disp			20h F						c. Location -	City or T	own State
	<u>'</u>	Removal from S	otate		sition (Name o natory or other		10/19		c. Lucation -	City or 1	own, State
	5 ☐ Other (Spec		GO€		hington						lle, MD
21. Signature of	Meral Service Lic	ensee	4		. Name and Ac		110	endon/Hal Lanham,			Home
23a. Pa . Enter the cock, or hea	he disease, or co irt failure. List on	mplications that can	aused the deat ach line.	h. Do not ente	er the mode of	dying, such a	is cardiac o	r respiratory arrest	t,		Approximate Interval Between
ediate Cause disease or condition	(Final	100	ite i	6019	ronni	chi	· ler	ystiti	5		Onset and Death
resulting in death)	4	Due to (or as a conseq	uence of):			100	gstill			
0	- distance	SOD	ticer	nia							9-9-08
Sequentially list con il ary, leading to in cause. Enter Unde	nations, inediate alvina	Due to (or as a sonseq	lientisi of):							-
Cause (Disease or that initiated events	injurý	o. Pro	umon	ia						- 10	Weeks
resulting in death) l	_ast	Due to (or as a conseq	uence of):							
		d									
	1								T		
IF FEMALE: 23b. Was decedent		23c. If yes, out	come of pregna		Ectopic pregr	ancu			23d. Da	te of deliv	ery
in the past 12 1 ☐ Yes 2 ☐			ant at time of c		Other (specify				Mo	nth	Day Year
9 Unknown		9 LI OTIKTI									
Part II. Other signif	icant conditions	contributing to de	ath but not resi	ulting in the un	nderlying cause	given in Part	I.	23e. Did tobac	cco use cont	ribute to t	he cause of death?
						· · · · · ·		1 ☐ Yes	2 📉 No	3☐ Pro	bably 4 Unknown
								24a. Was an	24b.	Were auto	opsy findings available
								autopsy performe	<u>d</u> ?	prior to co death?	empletion of cause of
25. Was case refer	red to medical					ae Di	on of Decar		No	1 □Yes	2 No
examiner?		Hospital:	anationt a 🗆	ED/Outrotic-		Other:		(Check only one)		(5	
27. Manner of Death		28a. Date of	of Injury	ER/Outpatien 28b. Time of	I 3 DOA	4 🗆 1		ne 5 Residence 8d. Describe how		- ' '	Ty)
1 Natural	5 Pending investigation	(Mont	h, Day, Year)	Injury	1	Injury at Work? 1 □ Yes 2 □	1	DOGGING HOW	,,		
2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not	he	of Injury - At ho	me, farm. stre				8f. Location (Stree	et and Numb	er or Rur	al Route Number
4 ☐ Homicide	determine	buildir	of Injury - At hong, etc. (Specif	y)	,, , , , , , , , , , , , , , , , ,		'	City or Town, S	State)	or or right	
29a. Certifier	1 Certifying F	hysician: To the	hest of my kno	wledge death	occurred at th	ne time date :	and place a	and due to the cau	se(s) and m	anner as	etated

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

10-16-08

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature and title

			for Amend Item State Registrar WCHD/SH	10eState of M 11/3/08 per	larylan FH	d / Depa <i>Ce</i> a	artment rtificate	of Hea	alth ar e <i>ath</i>	nd Mental I	Hygier Reg. 1	/ /	008	35	889
81	Dhysisi		1. Decedent's Name (First, Middle							2. Date of Month		Dav_	Year	3. Time of	
	Physicia /Medic		Glenn	Edward			Barkdo			Octob.			8006	5:05	Ам
7	Examin	er	4a. Facility Name (If not institution Fahrney-Keedy				4b. City, To	own, or Lo Isbor		Death	'		nty of Death hingto	m	
		.3	5. Social Security Number			last birthday)	If Under 1		Under 24		Birth		9. Birthr	place (State of	or Foreign
	Funeral Director		219-14-8063	1 X M 2□ F	83	Yrs.	Months	Days H	Hours	Min. (Month Nov.	Day, Yes		Coui	vland	0
g	a star of the		Usual Residence of Decedent			-									1 1 1 1 .
arylar	show	_	10a. State 10b. County			y, Town or Lo								10d. Inside Ci 1 □ Yes	•
he M	28a-f	Director		ngton	Воо	nsboro	10f. Zip C	`odo			100	Citizen	of What Cour		
with t	a or		10e. Street and Number 8507	Mapleville	RD		217				Tog.		U.S.A.		
d Z1Z15-UU36 filed within 72 hours after death with the Maryland	ns 23 musi	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.	S. 13.			anic Origin	n? (Specify Yes or Puerto Rican, etc.	No-	14. R	lace - Americ	can Indian,	
o after	or iter niner		1 ☐ Never Married 2 ☐ Marr	ied Armed Forces 1 X Yes 2 ☐ If Yes, Give	?] No		if Yes, specif 1 ☐ Yes 2		Mexican, i Specify:	Puerto Hican, etc.)	1	lack, White,		
5-0036 72 hours af	ral", Exar	d by	3 X Widowed 4 □ Divorced	Year or Dates:								Spe	wn:		
1 2 1	"natu adical	Completed	15. Deceden (Specify only higher	r's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use	done duri		f working	16b.	Kind of	Business/In	dustry	
Vithir	ene. than he Me	d m	Elementary/Secondary (0-12)	College (1-4or	5+)	Pilo		remed)			A:	irli	nes		
E P	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, <u>the Medical Examiner must be notified at</u>	Be Co	17. Father's Name (First, Middle,	Last)				18	3. Mother's	Name (First, Mid				_	-
yland ould be file	nked rked tic ev	To B	Henry Clinton H	3arkdo11				C	Cora	Elizabet	h Ho	rst			
Maryia id 2 should	and Nis mail		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street and	d Number	or Rural Route No	ımber, Cit	y or Tov	vn, State, Zij	Code)	
and 2	Health iem 27 i		Dawn M. Baker/N	Niece	1	8311	Old N	ation	nal P	ike, Boo				1713	
altimore, mit. Pages 1 a	t of H If itel or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation	3 ☐Removal from State	e	Place of Dispo emetery, cre			1	Date			n - City or To	,	
tim t. Pa	rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (S	pecify)	Smi					0/30/200					
e a	Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ever once.		21. Signature of Fulleral Service	Licensee		I .				Rest Ha ia Ave.,				_	742
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the deat						-		own, i	Approximat Interval Bet	te
-1	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Nend Due to (or a	s a conseq	luve uence of):								Onset and	
E	kaminer		Sequentially list conditions.	b. Endo	and	to							1		
p	sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseq	uence of):									
xecut	and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of):									
8760 ate be e	ohysician and the burial-transit	dical E													
68 /	g phy: as the	edic		0.				_							
ecords, P.O. Box 68/60, law requires that the death certificate be executed	been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth			⊒Ectopic pre	gnancy					Date of deliv		
o deal	he att ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant : 9□Unknown			Other (spe				_		Month	Day	Year
T ight in the contract of the	d by tl etach	Phy	9 Unknown Part II. Other significant condition		but not roo	ulting in the u	indorlying on	una airran i	in Port I	230 [and tobaco	TO HE O CO	ontribute to t	the cause of	death?
JS, ires th	signe I be d	by	ran II. Other Significant condition	ms contributing to death	Dut not les	uning ar are c	indenying cat	ase given i	iii r ait i.		☐ Yes	2 □ No		bably 4 🔼	
Hecords, he law requires t	peen	Completed									Acel ace				
The law	has ge 2 s	ld m								8	Vas an utopsy erformed		prior to co death?	opsy findings ompletion of c	cause of
⊢			25. Was case referred to medica	1				21	6 Place o	f Death (Check o		No	1 ☐ Yes	2□ No	
	is certific director,	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗍	ER/Outpatie	nt 3 □ DOA	Other:		ing Home 5□		6 🗆	Other (Speci	fv)	
اع Phy	h. After this funeral di	ı: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of In	ijury Dav Year)	28b. Time o	of 28	c. Injury at Work?		28d. Desci					
SIOI endir	death. ctor; Af y the fur	Certification:	2 Accident investig	gation		.,.,	M		s 2∐No)					
DIVISION I or Attending	ter de lirect n by t	ıţį	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 28e. Place of it	njury - At ho etc. <i>(Specil</i>		reet, factory,	office			on (Street Town, St		mber or Rur	al Route Nur	mber,
U Hospital o	eral C		200 Cortifica 4 Constitution	as Physician: To the bar-	et of my line	wladaa daa	th occurred -	t the time	data and	place and due to	the ec	0/6/	manno	etatad	
Hos	n 24 hours after death. ne Funeral Director; A oletely filled in by the fu	Medical		ng Physician: To the bes Examiner: On the basis and manner s	of examina										(s)
To the	within 2. To the I complet	Me	29b. Signature and title of certifie				29c.	License n	umber		29d.	Date sig	ned (Month	Day, Year)	
	> = 0) / Still	1 pm				DU	050	362		101	2910	18	
		3	30, Name and address of person	who compled cause of	death (Iten	n 23a) (Type	Print)	100	0 1	362 4sbeg	m		1702		5-1-2
311	141		Vincent A. Ch	Hone 2	2911	JEHER	sm E	ded .	1/1W	41-Dag	421) WI	700		
	Sta Registi		31. Date filed (Month, Day, Year)	151	strar's Signa		Annalla	æ							

35890 State of Maryland / Department of Health and Mental Hygiene 1 0 8

					C	ertificate c	of Death		Reg. No.		
			1. Decedent's Name (First, Middle, Le	st)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia	_	RAYFIELD	BOYD, JR	2.			Octobe			3:10PM
	/Medica		4a Facility Name (If not institution, giv		•		4b. City, Town, or			-	
	Examine	≱r			\1		0 11.1	1 1	Darina	a Cas	
			1147 Southview	Drive #10		If Under 1 Ye	Oxon Hill ear If Under 24 Hr			e Geo:	
	Funeral		5. Social Security Number 6. S	ID M 2□F	yrs. last birthda 50 Yrs	Months Da		. (Month, De	ey, Year)	Countr	ce (State or Foreign
	Director		5/8-80-4943	A	50 Yrs			Nov. 17	, 1957	Wash.	, DC
	2	ł	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or	Location				10	d. Inside City Limits
	aryle	_			•					100	1√2 Yes 2 □ No
	W F	용	Maryland Prince	George's	Oxon	Hill					X 103 2 110
	# 22 #	100	10e. Street and Number			10f. Zip Cod			10g. Citizen of \		y?
	h wi		1147 Southview	Drive #101		20745	5		USA		
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U,S. 1	3. Was Decedent	of Hispanic Origin? (Juban, Mexican, Pue	Specify Yes or No	o- 14. Rac	e - America	
		בֿ l	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕏 No				rto Rican, etc.)		ck, White, et	
20	1. o	ò	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yas 2 🔀 I	No Specify:		Specify	_{v:} Blac	CK
ş	hou tur	ᄝ	15. Decedent's E		16a De	cedent's Usual Oc	cunetion		16b. Kind of B	usiness/Indu	strv
15	n 72	Completed	(Specify only highest gre	ede completed)	(G	ive kind of work do a. DO NOT use re	ne during most of wo	orking			,
12	withi than	E	Elementary/Secondary (0-12)	College (1-4or 5+)			y Technic	ian	Pr	ivate	
2	led ygie	ပ္ပြဲ	17.5-16-16-16-16-16-16-16-16-16-16-16-16-16-			Sychiati	-		e, Maiden Suman		
Ē	be fi d ot	Be	17. Father's Name (First, Middle, Last,					•	_	10)	
<u>×</u>	should be filed within and Mental Hygiene. s marked other than turnatic event, the Mental Mental County the Mental County the Mental County the Mental County the Mental County the Mental County the Mental County the Men	잍	Rayfield	Воу	d, Sr.		Shirle	у	Hicks		
Maryland 21215-0020	2 sho end is me		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Str	eet and Number or F	Rurel Route Numb	ber, City or Town,	State, Zip C	Code)
Σ	and 2 ealth e n 27 is	-	Cortella B. Broo	ks. Sister	1147	Southvi	ew Dr., #	101 - Ox	on Hill.	, MD 2	20745
ē,	s 1 and 2 should f Health end Mer Item 27 is marke other traumatic	ı	20a. Method of Disposition	20	b Place of Di	sposition (Neme of	•		20c. Location -		
2	nd of		1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State R	iverda.	Te Park	place)	10 ⁰ /27 2008	Riverda	le. MI)
==	nit. Per entmen ortant: Injury		4 Donation 5 Other (Specif		Crema	atoery					
Baltimore,	permit. Peges 1 and Depertment of Health Important: If Item 27 any Injury or other tr once.		21. Signature of Funeral Service Lice	ISBE /			dress of Facility J				•
_	70 = 40			0/1/		4001 Ben	ning Rd.,	N.E Wa	shingto	ı, DC	20019
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not	enter the mode of	dying, such as cardia	c or respiratory	arrest,	1	Approximate nterval Between
	Physician		SHOCK, OF Heart failure. List only	Cause on each line.							Onset and Death
	/Medical		Immediate Cause (Final	SEIZURE 1	DISORDE	'R					
. 5"	Examiner		disease or condition resulting in death)	a							
		<u>ا</u> و		RESPIRATO	to (or as a con						
	bet isit -	n/Medical Examiner	_	b							
	and and I-trai	ž	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that instead each		to (or as a con:					į	
90	oe e.	ا ي	cause. Enter Underlying Cause (Disease or injury	END STAGE	KIDNE	Y DISEASE	5				
ox 68760,	certificate be executed nding physician and use as the buriel-transit	을 	that initiated events resulting in death) Last		o (or as a cons	sequence of):					
9)	ing p	Σ		HYPERTENS	ION						
ô	th ce	盲	_	d						1	
œ.	res that the death signed by the atter I be detached for	Pnysicia	Part II. Other significent conditions of	ontributing to death but not	resulting in the	e underlying cause	given in Part I.	23b. Did	tobecco use co	ntribute to	the cause of death?
P.O.	the by the ache	٢		-				1[Yes 2 No	3 □ Probr	ibly 4 Unknown
	that bed	S S									. –
g.	The law requires that the death ate has been signed by the atterpage 2 should be detached for	0						24a. Was	s an autopsy		e autopsy findings
ŏ	v require been sig should t	Completed						perf	omed?	com	lable prior to pletion of cause eath?
ĕ	has ge 2 s	ᄅ								01 06	eath?
=		3						10	Yes 2x No	10	Yes 2□ No
Ħ	certificate	ne ne	25. Was case referred to medical examiner?				26. Place of De	eath (Check only	one)		
2	S S D	9	1 Tx Yes 2 □ No	Hospital: 1 Inpatient :	2 ER/Outpa	tient 3 DOA	Other: 4 Nursing	Home 5 k⊋ Res	idence 6 □Oth	er (Specify)	
0	Ph eral eral		27. Manner of Death	28a. Date of Injury	28b. Time	e of 28c. I	njury et Work?		how injury occur		
<u></u>	ding th.		1 Natural 5 □ Pending Description Natural 5 □ Pending investigation	(Month, Day Yea	r) Injur		work? I∐Yes 2∐No				
S	Attending or death. sector: After by the fune	<u>ප</u>	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - A	At home, farm.	street, factory, offi	ce	28f. Location	(Street and Numb	oer or Rural	Route Number,
Division of Vital Records,	or Attendent efter deat Director: I in by the	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	,		City or To	iwn, State)		
_	urs urs illed	3						1			
	To the Hospital or Attent within 24 hours effer deat To the Funeral Director: Sompletely filled in by the	edicai	(Check only 2 Medical Exan	ysician: To the best of my niner: On the basis of exem	knowledge, de nination and/or	eath occurred at the investigation, in m	e time, date and plac ny opinion, death occ	e, end due to the urred at the time,	cause(s) and ma , date and place,	and due to t	tea. he cause(s)
	the the plei	20 H	one)	and manner stated.		1 0 - 1 :			004 0	a /44 =	nu Vanci
	To To To	-	29b. Signature and title of certifier				ense number		29d. Date signe	a (Month, D	_
	2		MISUEMA	my m	0-	D40	6551		ic	1211	2008
	800	-	30. Name and address of person who	completed cause of death ((Item 23a) (Typ	oe, Print)				1	
	AC		Buari A. Osman,				Suite 409) - Oxon	Hill M	D 207	45
	State		31. Date filed (Month, Day, Year)	32. Registrar's S		,	20200 40.				
	Registra	-	OCT 2 2 2008	M. M.	hart .						
				The second							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 8,19b per inf., 2889,03/20/09dhb Certificate of Death Reg. No. For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day A M Mary E. Botts October 0 14, 2008 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Country Companion Assisted Living Taneytown Carroll 8. Date of Birtt 06/21/1920 rthplace (State or Foreign (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1 □ M 2 🗓 F 88 Director 466-38-7817 Berwyn, Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f showevent, the Medical Everniner must be notified at Director 1 ☐Yes 2X No Maryland Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1704 Jermar Drive 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ⋛ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Nontal Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, I'm May once. College (1-4or 5+) Elementary/Secondary (0-12) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Harry W. Jewell Mabel Ruth Suit ပ 19a. Informant's Name/Relationship (Type. Print) 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21563 Monte Vista Terrace, Monte Rio, California 9546 Richard M. Jewell/Nephew 95462 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 18,2008 Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Month Year 5 Other (specify) 9 Unknown signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s performed Division of Vital 1 ☐ Yes 2 🗆 No 1 ∐ Yes 2 🎇 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Living 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 14, 2008

Registrar
DHMH 17 Rev 1/2001

21102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John ₩. Middleton, 3337 Victory St., Manchester, Maryland

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** BUNDY OCTOBER CORNELIA 2008 4:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Months Days Hours Min. 1 □ M 2 🖵 F 69 577-54-6920 1939 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5601 JUSTINA DRIVE 20706 USA Funeral 12. Was Decedent Ever in U.S. 13 Armed Forces? 1 □Xes 2 □ No AIRFORCE If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2**X** No Specify 2 Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th GOVERNMENT COMPUTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES C. BUTLER ပ EDITH GIBSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN BLOUNT/SON 1344 EAST CAPITOL STREET N.E. WASHINGTON, DC 20003 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) FT. LINCOLN CEMETERY 10-17-08 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that causeum shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine milden resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA

Examiner requires that the death certificate be executed burial-tran and physician a Physician/Medical attending properties for use as as ed by the a signed to Completed Jas page 2 certificate |

this funeral

After t

To the russim... within 24 hours after death.

To the Funeral Director: Af

Hospital or Attending

the 2 Funeral

Director

28a-f show

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72 hours after

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r be filed within

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it who lical Examinar must be notified at

Certification: To

Medical

1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	0057635	10 x 10 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

800 31. Date filed (Month, Day, Year) OCT 1 6

State Registrar

			For State Registrar		State of M	arylan		artment d r <i>tificate d</i>			/lental Hy	giene Reg. No	20	08	35893
			Decedent's Name (First)	Middle, Lasi	")						2. Date of De	ath	IV.	Year	3. Time of Death
7	Physici /Medic		ELIZABETH		BECK	HAM_					OCTOBE		•		1:45 A M
	Examin	er	4a. Facility Name (If not in:	_				4b. City, Tow	n, or Loca	tion of Death			. County		
	Funeral Director		10107 PRINC 5. Social Security Number 578-36-7336	6. Se		ie (In yrs. 1	last birthday) Yrs.	UPPER If Under 1 Ye Months Da	ear If U	BORO nder 24 Hrs. urs Min.	8. Date of Bi	PRINCE GE Birth Pay, Year) 9. Bir Co 20, 1929 CHA			lace (State or Foreign atry)
			Usual Residence of Deced	ent							JUNE Z	∪, ⊥	9291		
	arylan show	_		County	ODGD 1 G		y, Town or Lo							1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he Ma	ecto		NCE GE	ORGE'S	UPP	ER MAR		-10			10= C	tizen of M	/bot Cour	Λ.
	ath with the 23a or 3	Funeral Director	10e. Street and Number 10107 PRINCE	PLACE				10f. Zip Co.				UN	tizen of W	STA'	TES
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examina	δ	11. Marital Status 1 X Never Married 2[3 □ Widowed 4 □ Di		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent f Yes, specify (1 □Yes 2√		ic Origin? (Sp xican, Puerto ecify:	ecify Yes or No Rican, etc.))-	Blac	e - Americ k, White, d BLA	
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	filed within Hygiene. Ither than "		7th 17. Father's Name (First, M	Aiddle Last)	-						e (First, Middle				
an	d be f ental ced o	o Be		CKHAM							JOHNSO			-/	
Maryland	should be filed withi and Mental Hygiene. s marked other thar aumatic event, the M	ဥ	19a. Informant's Name/Re		ype. Print)		19b. Mailir	ng Address (St	reet and N		al Route Numb		or Town,	State, Zip	Code)
	atth a 27 is		CYNTHIA SA	UNDERS	DAUGHTEF	{	4545	DALLAS	PL.,	#202 '	TEMPLE	HILL	s. M	D. 20	0748
J.	of He of He litem		20a. Method of Disposition			20b. P	lace of Dispo	sition (Name o	f		Date				wn, State
Ē	Page ment ant: If ury o		1 X Burial 2 □ Crem 4 □ Dogation 5 □ O					OLN CEM		Y 10/3	1/08	BRE	NTWO	OD. 1	ΜD
Baltimore,	permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any Injury or other trau once.		21. Signature of Funeral S	ervice (icens	KNON	fal	// .	2. Name and A		u	APITOL , N.E.	MORT	UARY	-	20002
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أري	/Medical Examiner		resulting in death)		Due to (or as	a consequ									
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O. Box	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	Physician/M	IF FEMALE; 23b. Was decedent pregnin the past 12 months 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	ant	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pregr Other (specif					23d. Dat Mo	e of delive	ery Day Year
σ,	w requires that the dispension is been signed by the should be detached		Part II. Other significant of	onditions co	ntributing to death b	ut not resu	ulting in the u	nderlying cause	given in F	Part I.	23e. Did	tobacco	use contr	ibute to th	ne cause of death?
rds	quires an sign uld be	ed by									1 🗆	Yes 2	No.No	3□ Prot	pably 4 🗍 Unknown
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/ita	Physiclan: this certific ral director, I	Be (25. Was case referred to r examiner?	- H	Handlet.					Place of Deat	h (Check only	one)			
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Division	l or Attend after death. Director: /	Certification: To	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of Inj	ury - At ho	ome, farm, str			2 0.10	28f. Location	Street a	nd Numb	er or Rura	al Route Number,
Ö	after after Dire d in b	erti	4 Homicide	determined	building, et	c. (Specify	y)				City or To	wn, Stat	e)		·
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C			/sician: To the best Iner: On the basis of and manner st	of examina									
	To the within To the Comple	Me	29b. Signature and title of	obrtifier /	/				ense num						Day, Year)
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) 1		30. Name and address of	person who c	ompleted cause of o	death (Item	n 23a) (Type,	Print)							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - State Registrar		-	Cert	tificate of	Death		Reg. N	.2000	33034
7.	Dhyaisi		1. Decedent's Name (First, Middle						2. Date of D		av Year	3. Time of Death
	Physici /Medic		ROSA	MARIA		BROOF	KS —————		OCTOB1		17 2008	8:28P M
	Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, o	r Location of Dea	ith	4	c. County of Death	1
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1	Funeral Director		5. Social Security Number 578–82–0819		. 7	Yrs.	Months Days	Hours Mir		ay, Yea 2 19	61 WASI	HINGTON, DC
	pr ,		Usual Residence of Decedent		10c. City, To	un or Lon	otion		-			10d. Inside City Limits
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	he M 28a-f otifie	Director	MD PRINC	E GEORGES	CAP	TIOL	HEIGHTS 10f. Zip Code			100 0	itizen of What Cou	
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	death	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	/as Decedent of H Yes, specify Cub	lispanic Origin? (Specify Yes or N	lo-	14. Race - Amer Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by	1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		10		☐ Yes 2X No		rio modii, cic.,			BLACK
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lan	lid be lental rked o	To Be	JESSIE BROOKS					BAYLEAS	E ROBE	RTS		
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Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ceme	tery, cirem	ition (Name of latory or other pla AL CEMET		Date -25-2008		Location - City or TUREL, MAR	•
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89	ertificate ing phy e as the	Medical		u								
Box	eath c	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify) _	у			23d. Date of deli Month	very Day Year
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Re	The law te has age 2	Completed	ASTHM						- aut pei 1⊟ Yes	opsy formed? 2 2	death?	ompletion of cause of 2 🖾 No
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7	Physician: this certific ral director,	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 💢 Inpatie	ent 2 ER/0	Outpatient	3 □ DOA Oth	4 LI Nursing	Home 5 ☐ Re	sidence	6 □Other (Spec	cify)
0 0	ing Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Inju (Month, Day	ry 28b y <i>Year)</i>	. Time of Injury	28c. Inju Wo		28d. Describ	e how in	jury occurred	
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Division	after of Direct of In by	Certification:	4 ☐ Homicide determ	building, et	c. (Specify)	iaiii, suc	et, factory, office		City or T			rai noule Nullibel,
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	To the To the To the Compl	Me	29b. Signature and title of cortifie		1		29c. Licens				Date signed (Month	
				/lun!			MD.	20414		,	10/20/0	08
0	10		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type, F	Print)			,		
1			7. 000	AWAH 10	6 /RVI	NG :	ST NW	WAS	HINGTON	, 0	10/20/0	10
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 1 ch ae 20W.)11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Spars Hours Min. Starch II, Ame Arunde Arunde If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 14 M 2□F Months Year Washington, DC 577-74-1453 57 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
?? is marked other than "natural", or items 23a or 28a-f show traumatic event, it will be a marked at a marked other than "natural", or items 25a or 28a-f show traumatic event, it will be a marked at ty⊟Yes 2 □ No Directo Maryland Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Tyler Point Road 20751 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African 1 ☐ Yes 21s If Yes, Give Year or Dates: 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Police Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hobson L. Bowser Doris Lewis ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum 4220 Lane Place, NE Washington, DC 20019 Doris M. Bowser - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 tment of I Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery Oct 18, 2008 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Myo (wdia) /Medical Due to or as a consequence of): Examiner CRIEDROVALLY lar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence on, attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the all the detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🛠 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s was a... autopsy performed? Ves 2 No 25. Was case referred to medical examiner? this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital

9

State Registrar

Medical

anche lark 31. Date filed (Month) 7 2008

29b. Signature and title of certifier

29a. Certifier

(Check only

Medical

32. Registrar's Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Day. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malcolm Martin Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar		Cert	tificate of	Death			g. No.		
Physicia Medical Examir	n/	 Decedent's Name (First, Midd 	e,Last) Martin		2. Date of Death Month October 20	Day Y	/ear	3. Time of Death 1900 hrs			
		4a. Facility Name (if not institution 2251 Dawn Lane	on, give street and nui	mber)	1	4b. City, Town, or L Temple Hills	ocation of Death			ty of Death George	
Funeral	1	5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	h(MM/DD/YY	YY) 9. Bir Co	thplace (State or Foreign untry)
Director		579-90-6513 Usual Residence of Decedent	1 X M 2 F	44	Yrs			March 1	2, 196	54 Wa	shington, DC
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Maryland 28a-f show any d at once.	ÖL	10e. Street and Number	-		-	10f. Zip Code		10	g. Citizen of	What Cou	ntry?
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Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatite v.	٢	19a. Informant's Name/Relation: Andrea Brown				g Address (Street Dawn Lan					e, Zip Code)
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying I	Physician: To the beaminer: On the basis	of examination ar	ge, death occu nd/or investiga	urred at the time, da ation, in my opinion	te and place, an	d due to the caus at the time, date	se(s) and mar and place, a	nner as sta nd due to t	ated. he cause(s)
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician BROOKS** SR. S. 2008 CHARLES ctoper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LANHAM DOCTOR'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min 11 M 2□ F 72 220-28-6493 **Director** 1935 MARYLAND DEC 29, Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination is a partifical anone. Director LANDOVER 1 XYes 2 No PRINCE GEORGE'S MT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 USA 2306 ROMNEY COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No ARMY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔯 No Specify. BLACK Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6TH College (1-4or 5+) TRUCK DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILL **BROOKS** VERGIE GROSS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lottie M. BROOKS/WIFE 2306 ROMNEY COURT LANDOVER, MARYLAND 20785 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State VETERANS CEMETERY 10-28-08 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Decub tivs Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death Day 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform uealii? 1∐Yes 2∐No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

Box 68760. P.O. | of Vital Records,

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed attending p s been signed by the sale page 2 certificate has funeral director this After Division Hospital or Attending death. 24 hours after death Funeral Director: filled in by the

physician and s the burial-trans

completely within 2. 16 He

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determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8118 Good Lucked, Lanhoem, MD. 20706 Hansson mp. 8 (x, Year) g 32. Registrar's Signatur Thomas 31. Date filed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier

4 Homicide

(Check only one)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** FRANKLIN **BROOKS** OCTOBER 16 2008 1:51 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY
If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT 30 1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 249-56-8698 1 ★M 2 ☐ F Yrs. Director SOUTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at 1 X Yes 2 No. Director MD PRINCE GEORGE'S LANDOVER HILLS 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be 4070 WARNER AVENUE #B2 20784 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 Agyes 2 □ No ARMY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK ۵ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within the and Mental Hygiene.
27 Is marked other than r traumatic event, the M marked other than Elementary/Secondary (0-12) College (1-4or 5+ TRUCK DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILBERT BROOKS MILLY BUTLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l JOSSALYN D. FORD/DAUGHTER 2344 EVIAN COURT DISTRICT HEIGHTS, MARYLAND 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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any Injury or ott 1 ☐ Burial 2 Toremation 3 ☐ Removal from State RIVERDALE CREMATORY 10-24-08 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Fundral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CARDIO PULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPTIC SHOCK Sequentially list conditions, if any, reading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed as the burial-trans MYOCARDIAL INFARCTION and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical RESPIRATORY FAILURE ding 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 2 No O. 9☐Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No page 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: / 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide or / To the Hospital within 24 hours a Funeral 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the l 29d. Date signed (Month, Day, Year)
OCHOLOGIC 17(2008) 29b. Signature and title of certifier HyAthville MD20782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamilton 32. Registrar's Signatur 31. Date filed (Month, Day, Year, OCT 2 1 2008 Registrar

08-07791 Tekola B. Bekele Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Last) Tekola B. Bekele 1. Decoder's Name (First, Middle, Middle) 1. Decoder's Name (First,			For State		C	ertifica	ite of	Death					eg. No.		3. Time of Death
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П	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	/Medic		Barbara W.	Brice			October 1	4, 2008	9:20 p ^M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		r Location of Death	1	4c. County of Death	
		\$ ⁷	402 Dias Drive	The Mark to the same to the state of		shington If Under 24 Hrs.	I a Data of Dill	Prince Ge	
Ŗ.	Funeral		5. Social Security Number 6. Sex	M 2TF	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Couin	lace (State or Foreign
	Director		579-50-3796 Usual Residence of Decedent	73			June 16,	1933 DILIII	ngham, Al.
	/land ow at		10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits
	Mary 1-f sh fled	tor	Maryland Prince G	eorges Ft. Wa	ashington				1. Yes 2 No
	h the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	try?
	th wit	a D	402 Dias Drive		20744		τ	Inited Stat	es
	ems	by Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span. Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
9	or it	/ Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No	Specify:	3 1 1000 17 010.7	Specify: Bla	
8	ural";	q p	3 ☐Widowed 4 ☐ Divorced	Year or Dates:					
21215-0036	"nati	Completed	15. Decedent's Educ (Specify only highest grade	completed) i (Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of wor	king 16l	o. Kind of Business/Ind	lustry
12	withir ene. than than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	pt. of Stat	,	rt Ofa	Government	:
9 9	filed Hygid ther int, tf	ပ္တို	17. Father's Name (First, Middle, Last)		or or stat		ne (First, Middle, Mai	den Surname)	
an	d be ental ced o	o Be	Frederick Weldon			Rosa O	verstreet	·· - -···-,	
Maryland	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show in matic event, the Medical Examiner must be notified at	ဥ	19a. Informant's Name/Relationship (Typ	ne. Print) 19b. I	Mailing Address (Street	and Number or Ru	ıral Route Number, C	ity or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Kenyatta Scott Gr						773
Baltimore,	item othe		20a. Method of Disposition	comoton	Disposition (Name of crematory or other place	(e)	Date 200	c. Location - City or To	wn, State
E	Page nent c nt: If iry or		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	and Veteran		21/2008	Cheltenham,	Md.
aĦ	partir porta y Inju		21. Signature of Funeral Service License	/	22. Name and Addre		- P A		
m	S a m S		With alo	Zuca MOI USS	22. Name and Addre Alexande 5538 Mar	lboro Pi	kė/Forestv	ville, Md.	20744
			23a. P = 1. Enter the disease or complice shock, or heart failure. List only on	cations I at caused the death. Do no	t enter the mode of dyir	ng, such as cardiac	or respiratory arrest		Approximate Interval Between
E.	Physician		Immediate Cause (Final disease or condition	Uterus Cance:	r				Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequence of					
Ġ.	Examiner		Sequentially list conditions.						
	sit ad	ine	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	ecut and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)·				
8760,	icate be executed physician and s the burial-transit			Due to (or as a consequence of	,.				
387	icate phys s the	dical	d.						
×	eath certific attending p for use as	//Me	IF FEMALE:	3c. If yes, outcome pf pregnancy				23d. Date of delive	
. Box	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		Month Month	Day Year
P. O.	that the de led by the a detached i	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	_				
T.	The law requires that the death certifice has been signed by the attending lep 2 should be detached for use as	by Pi	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Records,	quire n sig uld be						1 ☐ Yes	2½ No 3☐ Prob	ably 4 □Unknown
ပ္ပ	s been s	Completed					24a. Was an	24b. Were auto	osy findings available inpletion of cause of
	The lav te has age 2	m o					autopsy performed	d? death?	
Viital		Be C	25. Was case referred to medical			26. Place of Dea	1 Yes 2 2 th (Check only one)	No 1 ☐ Yes	2□ No
>	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Oth	ar:		e 6 Other (Specify	7)
ō	g Ph ter th neral		27. Manner of Death	28a. Date of Injury 28b. Tin (Month, Day Year) Inj			28d. Describe how i		/
Ö	tending Physician: The leath. tor: After this certificate hat the funeral director, page	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Tear)		Yes 2 □ No			
Division or	or Attencath after death Director: I in by the	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura	Route Number,
	tal or rs aft	Certification:		, , , , , , , , , , , , , , , , , , , ,					
	tospi t hou unei ely fil		29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	ician: To the best of my knowledge, er: On the basis of examination and	death occurred at the tir	ne, date and place	, and due to the caus	e(s) and manner as st	ated.
	To the Hospital or Attending Physician: White 24 hours after death. To the Funeral Director: After this certification the funeral director, which is the funeral director.	Medical	one)	and manner stated.					
	5 1 × 5	-	29b. Signature and title of certifier		29c. Licens		/	Date signed (Month,	*
•	(115)		Januar ?.	100	140	26665	(Ct. 16,	7008
	de		30. Name and address of person who cor	mpleted cause of death (Item 23a) (T	ype, Print) Basil C		110: 1	11.11	ווים ארט פון
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signature	INISIL C	ourt -	upper	Var boro	NU 20114
	Sta Registr	-	DCT 2 3 ZUUS	It boarded					

	41		1 - For State Registrar	State of Ma	ryland / Depa	artment of F			giene () () ()	35901
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physic		Lillian	Annie	· 70/0	Ke		Month	Day Year	
	/Medi Examii		4a. Facility Name (If not institution, give		- 010	1	or Location of Deat		4c County of De	
	Lxanın	iei	30.2011001	Island	road	aino	or Ann	a .	Someto	o+
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9. Bi	rthplace (State or Eoreign
п	Director	-		M 30 F /	7 8 Yrs.	Months Days	Hours Min.	Month, Day	Year) - 1920	ountry) M/
			Usual Residence of Decedent		1.0				7700	7 17
	ylan		10a. State 10b. County	(10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ma	ţ	MD Domers	et	Phna	255 th	The			1. Yes 2 No
	h the	lre	10e. Street and Number		4	10f. Zip Code	,	1	Og. Citizen of What C	country?
	h with	Funeral Director	30281 Deal	15km	& FORCE	1 2/8	153		USA	
	deal	ner	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
9	after or its	F	Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give				to Hican, etc.)	Black, Wh	ite, etc.
93	ours	1 by	3 Widowed 4 Divorced	Year or Dates:		1 Yes 2 No	Specify:		Specify:	slack
21215-0036	within 72 hours after death with the Maryland ane. then "naturat", or items 23a or 28a-f show na Medical Exemination with the inclined at	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		dent's Usual Occup kind of work done		rkina	16b. Kind of Busines:	s/Industry
21	ithin Jen	du	Elementary/Secondary (0-12)	College (1-4or 5+)	O life.	DO NOT use retired	d)		Sila	
	Hygier Hygier ther th	Co	10		Prive	ate la	cregion	er	SEIT	
מ	be fill H d off	Be	17. Father's Name (First, Middle, Last)	c 2	lake		18. Mother's Nar	me (First, Middle, i	Maiden Surname)	
S	should be and Mental is marked of sumatic averaged	2	111000) DI	ake		MA	71e -	tinney	/
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	10	16a Informantis Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Addres Street	and Number or Ru	ıral Route Numbei	City or Town, State,	Zip Code)
	Health tem 27		Carolyn om	M) (la	ug/14 302	181 real	Island	to Phi	KESSHMM	MP 2183
ore	ages 1 nt of H : If ftan		20a. Method of Bisposition 1☑Burial 2 ☐Cremation 3 ☐F	Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	ce)	Date	20c. Location - City of	r Town, State
Ē.	Pages ment of I ant: If its ury or o		'4 ☐ Donation 5 ☐ Other (Specify)		Georgeton	un Bapti	ist Nu	U.1:081	Ocomok	e MD
Baltimore,	permit. Pages 1 a Department of Hes Important: If Itam any injury or oths		21. Signature of Funeral Service Licens	ee /	. 22	2. Name and Addre	ss of Facility		W. Is	abella st.
_	2011		CHT PU	MVS	L. K	ennie Sm	1ith ture	al Home	& Salisbur	y md 21804
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that eaused the	ne death. Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		east (Cancer				Onset and Death
	/Medical		resulting in death)	-	consequence of):	_ana				years
	Examiner		Conventially lies and disjunc	b						•
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscus or injury		consequence of):					
	cute	Examiner	that initiated events	C						
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760	ate be executed hysician and the burial-transit	Physician/Medical		d						
9	ng pt	Jed	IS SERVICE				-			
Вох	death certific e attending p id for use as	an/N	200. Was decedent program	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy	.,		23d. Date of de	livery
		sicla	in the past 12 months? 1 Yes 2 No	4 Pregnant at tin		Other (specify)	<i>,</i>		Month	Day Year
P.O	that the died by the detached	hy	9 Unknown	9∐ Unknown						
s,	requires that the een signed by th hould be detache	by F	Part II. Other significant conditions co.	tributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute t	o the cause of death?
rd	w require been si should t		(000					1 □ Ye	ıs 2.] N o 3∏.P	robably 4 Unknown
S	2 S D	ompleted	HTN					24a. Was a	n 24b. Were a	utopsy findings available
of Vital Record	о т <u>а</u>	E	DM					autops	ned? prior to death?	completion of cause of
ita	sician: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 ath (Check only on		3 2 □ No
>	di S	OB	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital:	2 ER/Outpatien	nt 3 DOA Othe	The state of the second		ince 6 □Other (Spe	ecifu)
	ding Phys th. After this funeral di	L.	27. Manner of Death	28a. Date of Injury (Month, Day Y					w injury occurred	icity)
ō	Attending is death.	atlo	1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investigation	(MOIRII, Day 1	rear) Injury		Yes 2 □ No			
Division	Atte	F	3 Suicide 6 Could not be determined	28e. Place of Injury	At home, farm, stre	eet, factory, office		28f. Location (St.	reet and Number or R	ural Route Number,
Ö	al or	Certification;	4 1 Tornicide	building, etc. ((Specify)			City or Town	, State)	
	ospit hour unera y fills		29a. Certifier 1 Certifying Phys	sician: To the best of r	my knowledge, death	occurred at the tim	ne, date and place	, and due to the ca	iuse(s) and manner a	s stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exami	ner: On the basis of ex and manner state	xamination and/or inv	estigation, in my or	pinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To t To tl	×	29b. Signature and title of certifier	,		29c. License			9d. Date signed (Mont	th, Day, Year)
}	0 = 1		Fred H	<u> </u>		2005	9931		10/20/08	
	LEAN		30. Name and address of person who	mpleted cause of dear	th (Item 23a) (Type.	Print)	2837			
	JUL									
	J ()		30434 Mount Ver	no Pl	Ini	ncess 1	Anny	MO	2185-5	
	J ()°	te	31. Date filed (Month, Day, Year)	32. Pagistrar's	s Signature	Print)	Anys	MO	21853	

08-08186 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 35902 Linda Jean Beemer 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 1800 hrs October 31, 2008 **Medical Examiner** Linda Jean Beemer c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number **Funeral** Foreign Maryland Months Days Hours Director 220-74-7356 M 2 XF 50 March 21.1958 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 X Yes 2 No 23a or 28a-f show notified at once. Maryland Washington Hagerstown with the Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. ō 21740 145 East Franklin 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X No Yes White Yes 2 X No specify: Specify: 3 Widowed Divorced If Yes, Give Year item 27 is marked other than "natural", r traumatic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than ", or other traumatic event, the Medical E Personal Residence 21215-0036 Homemaker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Henry Schrayer, Sr. Audrey Jane Seabolt Schrayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD James Clifford Beemer-husband 145 East Franklin St. Hagerstown, MD 21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Shanktown Cemetery 11-5-2008 Big Pool, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line √Medical Death Immediate Cause (Final disease Pneumonia caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed 23a, PII, 27, 28a-f, perME, G886 12/18/08 TT Physician/Medical attending physician or use as the burial -X UNPENDED certificate be Box 68760. 23d. Date of delivery IE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Ectopic pregnancy Month Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ₽ σ. Yes 2 No 3 Probably 4 ✔ Unknown Hip fracture Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes No page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Hospital: 1 Other: Nursing Home 5 Residence 6 2 V ER/Outpatient 3 Inpatient this 1 V Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 27. Manner of Death After Certification: 1 Natural subject fell 1 Yes 2X No Division Director: Pending death. 10/26/08 2:43 am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 145 E. Franklin Stagerstown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide residence To the Funeral I determined lagerstown, Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 1, 2008 O.C.M.E. an Granel

State Registrar

ÖRIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Robert Wesley Copes 2008 /Medical Oct 30 10:00 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis HealthCare -The Pines Easton Talbot 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Days Hours 218-34-8221 72 Director 16, 1936 Mar. Alabama Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MDCaroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 23365 Ninetown Road 21660 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∏ Yes 2**√∏**No If Yes, Give Robert Copes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3X Widowed 4 ☐ Divorced Year or Dates: "natural", er than "natur, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Salvage Industry Mechanic 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be West Copes ဂ္ Cora Lee Townsen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai Rodney Carter, Jr./Grandson 1715 Dudley Corners Rd., Millington, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 T Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) Spring Grove Nov.7, 2008 Denton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, Greensboro, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA Physician COLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence off-Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has birector, page 2 s 2 X No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🛣 🕩 Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural
2 Accident 5 Pending investigation Injury 124 hours after death.

Ne Funeral Director; A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hou **To the Fune** completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of eartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REESIDE CRNP 610 1)07 CHMANS

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

MOA

Year)

5 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item 31 State of Maryla State Registrar WCHD/SH 10/30/08 per VR Reg. No. 4 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 2008 Constancio Bane Castillo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Washington County Hospital</u> Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours Min Director 218**-**37**-**4973 30. 1924 Philippines Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exactings and be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13835 Pennsylvania Ave 21742 U.S.A. 12. Was Decedent Ever in U.S. Acmed Forces? 1 Mayes 2 □ No If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ۾ Specify: 3 ☐ Widowed 4 ☐ Divorced Filipino Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than wher traumatic event, Ins. M. 4 Production Ice Cream Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Francisco Castillo Vitaliana Bane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troone. Maria Teresa DeVore / Daughter 13835 Pennsylvania Ave. Hagerstown Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10/31/2008 | Smithsburg, Maryland 21. Signature of Funeral Syrvice License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACU TE **Physician** LIVER FMILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C LOSTRIBLUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-transit WALDONSTROM MACROGLOBULINEWIA Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical CITRONIE ENAL FHILURG the attending pl IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 THROM BOGTTO PENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1∐Yes 2⊠No Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral to 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0006 00-6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALTAILO

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32. Registrar's Signature

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PARKWAY GREGOBELT MARTHAN

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Day **Physician** Annie Love Carter 2008 9:50 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Thomas More Nursing Home Prince George's Hyattsville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🗹 F 428-14-5292 88 Director July 20, 1920 Mississippi Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f show the Medical Eventine is ust be notified at 1 Yes 2 □ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with the neath of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or item or other traumatic event, the Modical Event in a not be in 4922 LaSalle Road 20782 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American India Black. White, etc. African 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Alfred Cole Millie Haynes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Gill - Niece 658-Oglethorpe St., NE Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 Paurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Oct 21, 2008 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licen & e 22 Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artenoscienotic Candiovascular **Physician** 4-0046 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🖪 No Year Month Day 5 ☐ Other (specify) ed by the detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ cate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred Injury at Work? 1 Matural 5 Pending investigation 1 □Yes 2 □No after death 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 29c. License number 6 Name and address of person who completed cause of death (Item 23a) (Type, Print) seensbury Rel Hyattsuilfe MD Zerr81 DE 31. Date filed (Month, Day, Year) State Registrar

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920	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 ☑Yes 2 ☐ If Yes, Give Year or Dates:	No	13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic cify Cuban, Me 2 ☑No Spe	kican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: B1 a	e, etc.
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene. other than "natur ant, the Medical	Completed by	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or		Decedent's Usu Give kind of wo life. DO NOT u Bart	al Occupation ork done during se retired) ender	most of work	ring	1	otel	Industry
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Balt	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service Licen	Ruber	my						13 6th n,DC 2	osti ^{NW}
	Physician /Medical		23a. Part 1 Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each l	ine.	EPS	23		or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as	a consequence of		vmo	NIA	· · · · · · · · · · · · · · · · · · ·			
68760,	icate be executed physician and s the burial-transit	<u>a</u>	resulting in death) Last	Due to (or as	a consequence of):						
O. Box 6	at the death certificate by the attending phys tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 Ectopic 5 Other (s				2	23d. Date of de Month	livery Day Year
σ.	The law requires that that the has been signed by bage 2 should be detact		Part II. Other significant conditions	ontributing to death b	out not resulting in	the underlying o	ause given in F	Part I.	1			o the cause of death?
Il Records,		Completed by		14					24a. Was auto perf 1 □ Yes	s an opsy ormed? 2,470	prior to death?	utopsy findings available completion of cause of s 2 [LIN6
Vital	Physician: The this certificate and director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 I Inpati	ient 2 ER/Out	patient 3 □ D	Othor: a		th <i>(Check only</i> ome 5□ Res		Other (Spe	ecify)
ion of	D le le	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da			28c. Injury at Work? 1 ☐ Yes		28d. Describe			
Division	il or Attendin after death. I Director: Af d in by the fur	ertification:	3 Suicide 6 Could not be determined	26e. Place of In	jury - At home, farr tc. (Specify)	n, street, factor	y, office			(Street an wn, State		ural Route Number,

To the Hospital or Attending Physician: The law requires that within 24 hours after deals.

To the Funeral Director: After this certificate has been signed b completely filled in by the funeral director, page 2 should be deta þ Completed Be

Certification: To

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number DO057124 29d. Date signed (Month, Day, Year) 10125108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD 9715 Medical Center Dr. #201 Rockville, Md 20850

State Registrar 31. Date filed (Month, Day, Year) OCT 2 7 2008

29a. Certifier (Check only one)



Eartha Capers C	e or Foreign
Fartha Capers Getober 13, 2008 21.4 Analysis of the institution, give steel and number) Analysis of the institution of the i	ge se or Foreign
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Physician //Medical Examiner 23a. Part I. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval forest and interval fores	
Physician //Medical Examiner 23a. Part I. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval forest and interval fores	
Shock, or heart failure. List only one cause on each line. Interval Examiner Physician Medical Examiner Medical Examiner	
Physician /Medical Examiner Page 1	letween
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	کرم
Due to (or as a consequence of): The content of the content of	
FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Dat	
FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Dat	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 248 Wes an although distribution of the cause o	Year
1 Yes 2 No 3 Probably 4	f death?
24a Was an 24b Was automy findin] Unknown
Political Probabily 4 Land Probability 4 Land Prob	is available f cause of
Check only one Chec	
2 9 1 1 Yes 2 No 1 I I Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Norsing Home 5 Residence 6 Other (Specify)	
25. Was case referred to medical examiner? 1	
2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined electroniced 28e. Place of Injury. At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route N	umber.
28a. Date of Injury 28b. Time of Section of	11110011
Pending Pend	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year	∋(s)
15 Smilline Working Do1852 October 16 20)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) See Double A. DEJORE MD Y23 Queenshing, Rel Hyattsu; He Mis)
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature)

			1 - For State of Maryla		artment of H			ene g. No. 2008	35911
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		MILDRED G. CLARK				Month OCTOBER	Day Year 18, 2008	2158 M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			SOUTHERN MARYLAND HOSPITAL		CLINTON			PRINCE GE	ORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign
	Director		5/7-28-9/12 89	Yrs.			APRIL 28	, 1919 VA	
	and		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation				0d. Inside City Limits
	f sho	ō						ļ	1 X Yes 2 □ No
	the Maryland 28a-f show	Je C	MD CHARLES W 10e. Street and Number	ALDORF	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	3a or	Ö	70 VILLAGE STREET 407		20602			JSA	,
	ns 2	by Funeral Director	11 Marital Status 12. Was Decedent Ever in	n U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba			14. Race - Americ	an Indian,
٥	or ite	Ē	1 Never Married 2 Married 1 Yes 2 No				o Rican, etc.)	Black, White,	etc.
2-003p	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ant, the Medical Evaniner must be notified at	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		I∐Yes 2∭INo	Specify:		Specify: BL	ACK
ה	72 hc natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	durina most of worl	kina 1	6b. Kind of Business/Inc	dustry
7	ithin ne. han "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired)	9		
V	led w lygie her t		12TH 17. Father's Name (First, Middle, Last)	CLERI	<u>X</u>	10. Mathada Naw	ne (First, Middle, M.	US GOVERNM	ENT
and	he fintal hed of	Be	, , , , , , ,				E LUMPKIN	•	
Š	hould d Me mark matic	은	BRANCH WILSON GAINES 19a. Informant's Name/Relationship (Type. Print)	10h Mailin	on Address (Street			City or Town, State, Zip	Codel
<u> </u>	id 2 s lth ar 27 is trau		IDA GAINES MOORE / SISTER		ILLAGE ST				_
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Healith and Mental Hydene. Department: If tem 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Marical Examinar must be any Injury or other traumatic event, the Marical Examinar must be an once.				sition (Name of natory or other plac			Oc. Location - City or To	
altimor	ages ent of nt: If I		La Buriai 2 Li Cremation 3 Li Hemovai from State			i	5 2009	SUITLAND, N	470
	nit. F Partm ortar Injur		21. Signal Fundrat Servic Licensee		MORIAL CE . Name and Addres			FUNERAL HO	
ă	lmp any		DONALD R.		308 SUITL				746
			23a. Pand. Enter the disease or complications that caused the d						Approximate Interval Between
	Physician	Q X	shock, or heart fallure. List only one cause on each line. Immediate Cause (Final	.36	Myder		I. fort	n	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a constitution)	sequence of):	מושעני	1 1	F ~ (1. 0).)	
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-	בי ס	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	sequence of):					
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×	e law requires that the death certifi has been signed by the attending te 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pre	gnancy					
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j.	the d y the ched	ıysi	1 Yes 2 No 9 Unknown 9 Unknown	or death 3L	Tottler (apeciny)				
Γ.	that ned b deta	y P	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
cords,	quires n sig ald be	d by					1 ☐ Yes	s 2 ☐ No 3 ☐ Prot	oably 4 Unknown
000	s bee	Completed					24a. Was an	24b. Were auto	psy findings available
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<u> </u>	an: ' rtifica tor, p	Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2, th (Check only one	Yes 1 ☐ Yes	2 L No
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5	ng Pt fter th neral	L:	27. Manner of Death 28a. Date of Injury 18△Natural 5 Pending (Month, Day, Year	28b. Time of Injury	28c. Injury Work		28d. Describe how		,
VISION	endin sath. or: A he fu	atic	2 Accident investigation			Yes 2□No			
Š	or Att ter de irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	t home, farm, streecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
ב	oital curs af								
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours affector: Within 24 hours affector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier the best of my (Check only one) and manner stated.	knowledge, death nination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the ca rred at the time, da	ause(s) and manner as s ate and place, and due to	stated. the cause(s)
/	To th To th	Me	29b. Signature and title of certifier		29c. License	e number	1	d. Date signed (Month,	Day, Year)
	6	,	b 4~		MODE	04105	5 1	90/18/10	
	()		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)				
	AL		Eric Medonald 750:	3 Sur	attsT	119.05	nton r	Md 207	35
	Sta		31. Date filed (Month, Day, Year) OCT 2 3 4000 32. Registrar's Si	gnature					
	Registr	ar	MORNING TO THE PARTY TO MAKE THE	-					

Funeral Director 28a-f show ò hRistlan, Elizabeth 23a

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Elizabeth Stubbs Christian October 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 28, J 5. Social Security Number 9. Birthplace (State or Foreign Country)
1920 Maryland 7. Age (In yrs. last birthday) 1 M 2 F Months Yrs. 218-20-1242 Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits other traumetic event, the Medical Examiner rust be notified at Prince George's Glenarden Directo Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 United States Funeral 1507 - 3rd Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Black Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is merked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Harry Stubbs Mary Queen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alonzo T. Christian - Son 1590 Loch Lomond Trail, SW Atlanta, GA 30331 27 permit. Pages 1 and Department of Healt Importent: If item 2 eny Injury or other: once. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park Oct 24, 2008 Landover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part1. En r the disease, r complications that caused the shock, reart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asystole disease or condition resulting in death) minute /Medical Due to (or as a consequence of): Examiner myocardial my arctier minules Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner public (or as a law requires that the death certificete be executed the burial-tran and Due to (or as a consequence of); Box 68760, attending physician Physician/Medical as 1 IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 🕱 No P.0. the 9 Unknown á signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Immay Embolism HyperTeuson icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed moulin de New med 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No atnothmillater certificate 1 ☐ Yes 1 ☐ Yes 25. s case referred to medical examiner? dlrector, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. n 24 hours after death.

e Funerel Director: A pletely filled in by the fi 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the 29c. License number 29b. Signature and title of certifier dentes mo 29d. Date signed (Month, Day, Year) D24720 10-21-2008 RAVINDER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAF) LANDOVER CHEVERLY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 PM **Physician** Ella 10 2008 /Medical 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Breanch DRIVE Salisburg Wicomico Burn Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 220-26-2142 Director -1930 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Wicomico Salisbury MARY LANCE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2180 BURNI BRANCH USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify. 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) artment of Health and Mental Hygiene ortant: If Item 27 is marked other than 'injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) NONE Domestic 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTHA Wilson) ANIEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury FARRARE JOUCE - NIECE GUEEN Md 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If II any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State WESLEY CEM. 4 Donation 5 DOther (Specify) 10-27-08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewar Bladys Salis DEWAR tuneral HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) - Vennicular Am **Physician** ASCND /Medical Due to (or as a consequence of): CARDIUMYPATH Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physiclan the for use as IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d Completed by perterm'in 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed) certificate 2 No or Attending Physician: director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred atural 5 ☐ Pending investigation Accident 1 Yes 2 No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

OCT 28 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

2503B,

10/28/08

SHURIZ SALISBUM, M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:22 AM W. Carey Ralph October 23, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico 30020 Deer Harbour Drive Salisbury 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 10/8/1938 1 X M 2 □ F Maryland 70 219-34-3459 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 □Yes 2 No Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 30020 Deer Harbour Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc I X Yes 2 No If Yes, Give AlrForce Year or Dates: 1 Never Married 2 Married white 1 □Yes 2KNo Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public utility Administrative clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Carey Minerva Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotta Carey/wife 30020 Deer Harbour Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/08 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Park 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic non small cell concinomo of Immediate Cause (Final Tulun9 6mo disease or condition resulting in death) 2mo Onganie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be execu 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Box 68760, Physician/Medical P.0. Records, 2 Completed Division of Vital director, Be Certification: To completely filled in by the funeral

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?? is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

and Menta! Hygiene.

Department of Health ar Important: If Item 27 is any injury or other trau once.

Physician

/Medical Examiner

altimore, Maryland 21215-0036

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) D0014314 October 27,08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Court Street. Salis bury, M.D. 21801 M.D. 145 & TIGNAG 31. Date filed (Month, Day, Year)

State Registrar

Medical

2008 28

32. Pegistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08170 State of Maryland / Department of Health and Mental Hygiene Richard Lee Dregney 2008 3591 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 31, 2008 0831 hrs Medical Examiner Richard Lee Dregney c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton 6635 Powhatan Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Hours Min Months Days Country) Director 02/02/1948 1 X M 2 60 Yrs 185-40-6242 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b, County 10a, State any Y Yes 2 No 28a-f show Clinton Prince Georges 23a or 28a-f sho notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20737 6635 Powhatan Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be in Armed Forces? 1 Never Married 2 X Married Yes 2 X No White Divorced If Yes, Give Year Yes 2 X No specify. Specify: Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Parks and Planning Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clair Dregney Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11211 Lakeside Dr., Dunkirk, MD 20754 Tracie Dregney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 11/3/08 Beltsville, MD Chesapeake Crem. Donation 5 Other Specify: 22. Name and Address of Facility Raymond-Wood F.H., 21. Signature of Funeral Service Licensee PO Box 430, Dunkirk, MD 20754 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical Death Atherosclertoic cardiovascular disease and fibrosis Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): liver Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and AMENDED 23a,27, permE, g885 11/26/08 TT Physician/Medical X UNPENDED attending physician or use as the burial -23d. Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown ۵. Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? certificate has performed? ✔ Yes 2 1 🗸 Yes 2 No No 26 Place of Death (Check only one) 25. Was case referred to medical Be of Vital Other₄ Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene FR/Outpatient 3 Inpatient 2 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 Division Pending the Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc e Funeral Direc Could not be or Town, State) Suicide determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 1, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 5 2008 State Registra

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Donald Christopher DeSantis 29,2008 12:58 p.[™] October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington 419 Linganore Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 8, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign
Country) **Funeral** 1 1 X M 2 □ F 1954 Washington,DC 53 212-68-2721 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Hagerstown Marvland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ö 419 Linganore Avenue 21740 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Follows: 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: **Korean** 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 white 6 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. framing carpenter construction 4.2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Ralph DeSantis Gloria Leslie ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Keely DeSantis - wife 419 Linganore Ave., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 11/3/08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Lie 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter tracing of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical thet ası IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | the detached 9 Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performs certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H 4+1 32. Registrar's Signature Month, Day, Year! State 3 OCT 2008 Registrar

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Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	0 1.4		30. Name and address of pe	rson who	completed cause of	of death (Item	23a)								
State 31. Date filed (Month, Day Year) 32. Registrar's Signa fre	WITT							nn Street,	Baltimo	ore, MD 2	1201				
		ate	31. Date filed (Month, Day)	8 ^{r)}	32. Regis	trar's Signa	Bell	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10/14/2008 7:15p Fred Leonard Dunn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner # 203 Prince George's 908 Marcy Ave. Oxon Hill 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/23/1939 Birthplace (State or Foreign Country)
 NC Funeral Months Days Hours Min. 11 M 2 □ F **Director** 68 240-60-6812 Nash County Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experience must be notified at Director tyEYes 2 □ No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 908 Marcy Ave. # 203 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∏Yes 2 ☑ 1 Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other tremment. 12 Detailer Car Wash 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joe Dunn Susie Battle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavonda Dunn 13008 Silver Maple Ct. Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Spectly) Shilo Church Cem. 10/18/08 | Whitakers, NC 21. Signature of Funeral Service Lenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a echesquence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s autopsy performe certificate 1□Yes 2 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes 2 1 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 □ Yes 2 □ No after death Director: A d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

completely within 2 To the I 13 290

Registrar

(Check only

31. Date filed (Month, **OCT 16**

29b. Signature and title of

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2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

n ol r	Registrar 1. Decedent's Name (First, Middle, Last) Webster Davis Ia. Facility Name (If not institution, give street and not institution)		Certificate of		2. Date of De		الزال	3. Time of Death
n ol r	Webster Davis la. Facility Name (If not institution, give street and n							
r 4	la. Facility Name (If not institution, give street and r				Octobe	r 13, 2	Year 008	2218 ^M
	D C TI + 1	number)	4b. City, Town, or	Location of Death	1		ty of Death	
	P.G. Hospital		Cheverl	.у		Prin	ce Geo	orge's
1	5. Social Security Number 6. Sex	7. Age (In yrs. last birt	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıv. Year)	Coun	lace (State or Foreign try)
	579-16-5459 Usual Residence of Decedent	88	Yrs.		June 1	1,1920	D.C.	
-	10a. State 10b. County	10c. City, Town	n or Location				11	0d. Inside City Limits
į	D.C.	Washi	ngton					1⊠Yes 2□No
Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	f What Coun	try?
	5000 Nannie H. Burrou	ghs	2001	.9		U.S.	Α.	
runerai	11. Marital Status 12. Was De Armed	ecedent Ever in U.S. Forces?	13. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		ace - America	
בן בו	If Yes,	Give	1 ☐ Yes 2 🛣 No	Specify:				
			Decedent's Heuri Occum	ation				
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ق ا	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle			
	Unknown			Unknowi	n			
	19a. Informant's Name/Relationship (Type. Print)							
						Washing	ton, I	OC 20006
1		comatai	f Disposition (Name of ry, crematory or other plac	ce)	Date	20c. Location	ı - City or To	wn, State
	4 □ Donation 5 □ Other (Specify)	Ft. Li						
	21. Signature of Funeral Service Licensee	offiler						
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	Sequentially list conditions, b.							
au l	if any, leading to immediate Due cause. Enter Underlying	to (or as a consequence	of):					
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Ž						23d. D	Date of delive	ery
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nys	9 □ Unknown 9 □ Un	known						
y L	· ·	ū	n the underlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
9	Multiple decubitous ul	.cers			1 🗆	Yes 2 □ No	3 ☐ Prob	ably 4K∏Unknown
D E	Coagulase staphyloccus	s sepsis				an 24t	o. Were auto	psy findings available mpletion of cause of
<u> </u>					perf 1□ Yes	ormed? 2⊠No	death? 1 ☐ Yes	
	examiner?			26. Place of Dea	th (Check only	one)		
<u> </u>	1 ☐ Yes 2 ☑ No Hospital: 1		itpatient 3 DOA	4 LI Nursing H				y)
<u>.</u>	1 X Natural 5 ☐ Pending (M				28d. Describe	how injury occ	urred	
cat	2□ Culded 6□ Could not be	and of lainer. At home fee		Yes 2∐No	00()	(0)		(B. + N.)
	determined 200.110	ilding, etc. (Specify)	irm, street, factory, office		City or To	wn, State)	nber or Hura	il Houte Ivumber,
	29a. Certifier 1 X Certifying Physician: To	the best of my knowledge	e, death occurred at the ti	me, date and place	and due to the	cause(s) and	manner ae e	tated.
<u>5</u>	(Check only 2 Medical Examiner: On the	e basis of examination an						
Ē ⊢	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
	1		D31	528		10-	-14-	2008
-	30. Name and address of person who completed co	ause of death (Item 23a)					2078	5
	Margaret Akdan, MD			1 Center,	3001 F	lospital	l Dr.	Cheverly,
е		2. Registrar's Signature						
	To be completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade complete	15. Decedent's Education 16a. 1	15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's property only highest grade completed 162. Decedent Susual Ocupe 162. Decedent Susual Ocupe 163. Decedent Susual Ocupe 164. Decedent Susual Oc	Security Security	Tyes Can College Tyes College Colleg	Type: Series Specific Speci	Specify Blad Specify Blad Specify Blad Specify Blad Specify Specify Blad Specify
State of Maryland / Department of Health and Mental Hygiene For State CT Registra/mend#'s17.18.PerInformantPQC11-5-08Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lillie Dunning 19 12:20A.M 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clinton Prince George's Bradford Oaks Nursing Home If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11/02/1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min Months Days 1 □ M 2 🛛 F Director 428-62-5889 Usual Residence of Decedent a filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be nettled at 1X Yes 2 □ No Director Prince George's MD Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 6909 Groveton Drive Prince George's Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No B1ack Specify 2 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FBI/Federal Government Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ouida Joseph Lee 2 Robert Lee Quida Strickland McGree 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Nicole Dunning/Daughter 6909 Groveton Dr., Clinton, MD 20735 permit. Pages 1.
Department of He
Important: If iten
any injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) Resurrection 10/24/2008 Clinton, MD 21. Signatura of Funeral Se 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 P rt1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia resulting in death) /Medical Due to (or as a consequence of): Examiner Arterioscleratic Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: 1 □Yes 2X No 1 ☐ Yes 2 🗆 No al or Attending Physician; Ts after death.
In Director; After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number D35206 10/20/2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd., #101, Ft. Wash., MD 20744 William Tanner, 31. Date filed (Month, Day, Year) State OCT 2 7 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Wayne Davis October 0 9:55PMM 16, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9211 Stewart Lane / Clinton Nursing Home Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 → M 2 □ F Days Hours Min. Maryland Director 217-68-6354 54 May 13, 1954 Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ever it not need to some once. MD \mathbf{FG} Oxon Hill Yes 2□No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Ovens Road #603 20745 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🔯 No Specify Specify: Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Picture Framer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Davis Mary Curtis ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an Health em 27 l Ruth Samuels - Sister 15500 Baden Westwood Road; Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Chesapeake Crematory 10/20/2008 Beltsville, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 1918 4594 Beech Road; Temple Hills, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 200 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifie ause of death (Item 23a) (Type, Print) 31. Date filed (Month Day, 32. Registrar's Sign State NOV 0 3 2008

Registrar

Box 68760.

P.O.

Division of Vital Records,

08-07912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

icheal Dulski		State of Maryland / Department of For State For State Certificate of L			, No. 20	08 3592
Physician	/ 1	. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 0516 hrs
ledical Examine		Michael S. Dulski a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	October 21	, 2008 4c. County of Deat	
			Lanham		Prince Georg	1
Funeral .	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	-		rthplace (State or Foreign
Director	L	388-52-5467 1XM 2F 59 Yrs.	Months Days Hours Min.	June 20		lwaukee, WI
	_	Isual Residence of Decedent)			10d. Inside City Limits
how a	_ ^	Maryland Prince George's New Carrollt	'on			1 X Yes 2 No
the Maryland a or 28a-f show any tifled at once.		the state of the s	10f. Zip Code	10	g. Citizen of What Cou	intry?
ith the Maryland 23a or 28a-f sho notified at once		6431 Fairbanks Street	20784		USA	
72 hours after death with the Maryland "n"matural", or items 23a or 28a-f she al Examiner must be notified at once looked by Ermoral Director	le la	Never Married 2 X Married Armed Forces? If Yes	Decedent of Hispanic Origin? (Sp , specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
ler dez ", or i	- 1	1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1968–1973 1 Y	es 2 X No specify:		Specify: Wh	nite
ours aft	<u> </u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kind of v		16b. Kind of Business	/Industry
36 n 72 h nan "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Cook	(60)	Culinary	
-00% de within spiene.	Ē -	7. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, M		
		James Dulski, Sr.	June Bu	rg		
	- 1	112	Address (Street and Number or F			
		Linda Lorraine Dulski / Wife 6431 For the following the following follows:	airbanks Street on (Name of cemetery,	Date Date	20c. Location - City of	
Baltimore, permit. Pages I and Department of Heal Important: If iter injury or other tra		1 Burial 2 X Cremation 3 Removal from State crematory or othe	rplace) an Crematory 10/	25/2008	Alevandri	.a, Virginia
altin nit. Pa nartmer sortan iry or		4 Bellater 6 Ctre occury.	me and Address of Facility	23/2000		imore Ave.
	1	Claudette Bash Larning Gas	ch's Funeral Ho	me, P.A.	Hyattsvil	lle, MD 20781
Physician Medical	1	3a. Part I. Enter the disease, or complications that caused the death Do not enter the failure. List only one cause on each line.		r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		mmediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardio Due to (or as a consequence of):	vascular Disease			Deau
		Sequentially list conditions, b				
	۱⊒	f any leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
sd asit	ا <u>ج</u>	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
execut ian and ial - tra	ledical	d. UNPENDED AMENDED				
Box 68760, c death certificate be ex the attending physician ed for use as the burial	ğ İ	F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the			23d. Date of delive	,
Ox 6876 eath certificate s attending phy for use as the	Sician/N	past 12 months?	al death 3 Ectopic pregna er (Specify)	ancy	Month	Day Year
BO)	≥	1 Yes 2 No 9 Unknown g Unknown				
P.O.		Part II. Other significant conditions contributing to death but not resulting in the un Liver Cirrhosis	derlying cause given in Part I.	-	bacco use contribute to	obably 4 V Unknown
ds, I	Completed by	Liver Offiniosis		24a. Was a	an 24b. Were	autopsy findings available
e law r	ᇍ			autop	med? death?	
Division of Vital Records, lat or Attending Physician: The law requirers after death. al Director: After this certificate has been a been on the funeral director, page 2 should the fineral director, page 2 should a state of the fineral director.		25. Was case referred to medical	26.Place of Death (Check	only one)	2_No 1 🗸	Yes 2 No
Vita	lo Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	3 DOA Other Nursi	ng Home 5	Residence 6 Oth	er:
ding Ph	5	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury (Month, Day,Year)	jury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sior Attend r death ector: by the	<u></u>	2 Accident Investigation 28e Place of Injury - 4t home farm street		28f Location (5	Street and Number or I	Rural Route Number, City
Divis	Certification:	Suicide 6 Could not be determined (Specify)	,	or Town, S		
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	ed at the time, date and place, and	due to the caus	e(s) and manner as st	ated.
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	29c. License number	at the time, date	and place, and due to	
11/2	-	Aug T	O.C.M.E.		October 22, 20	
100	-	30. Name and address of person who completed cause of death (Item 23a)				
5		Ana Rubio MD. Assistant Medical Examiner 111 Penn St	treet, Baltimore, MD 2120	1		
Sta Registr		31. Date filed (Month, Day, Year) OCT 2. 4 2008				
DHMH 17 Rev 1/200		ORIGINAL			DOME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 00 M N 200 12 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death 0/15 Nde Gen, Social Security Numbe 7. Age (In yrs. last birthday Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 □ F Months Days Hours Min. 68 273-36-9325 AUGUST 6, 1940 PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits QUEEN ANNE'S 1 ☐ Yes 2 X No MARYLAND CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 345 CINNAMON TEAL DRIVE 21617 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No WHITE Specify Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROJECT MANAGER **IBM** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN A. ELMES HELEN S. HORNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLANE ELMES/WIFE 345 CINNAMON TEAL DRIVE, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of OCTOBER 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2008 STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, SUTH LIBERTY STREET 21. Signature of June CENTREVILLE, MARYLAND 21617 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VIO Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) il ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

,or

than "natural"

Hygiene.

permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, III

72 hours after death with the

Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical <u>Ş</u> Be Completed

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed burialphysician the the attending plone that the as the signed | | be det page 2 should has certificate funeral director, this After 24 hours after deatle Funeral Director: filled in by the

Division of Vital Records, P.O. Box 68760,

9 Unknown

1 🔲 Inpatient

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐Yes 2 ☐No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h building, etc. (Spec	ome, farm, street, factory office	2 🗆 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Rou City or Town, State)
29a. Certifier 1 Certifying Phy	sician: To the best of my kn	owledge, death occurred at the time, o	date and place	e, and due to the cause(s) and manner as stated.

25. Was case referred to medical examiner?

2 No

1 Yes

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number City or Town, State)

(Check only one)	2 Medical Exam	niner: On the basis and manner	s of examination and/or investig	gation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
29b. Signature and	title of certifier	~	Deputy	29c. License number	29d. Date signed (Month, Day, Year)

29c. License number

cause of death (Item 23a) (Type, Print) ess of person who complete

mD 32. Regis r's Signature

31. Date filed (Month, Day, Year) 2008 OCT

completely

the within To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Eugene Cary Edmondson October 19, 16:19 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clintan Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 √M 2 □ F Months Hours Days 243-56-7924 78 08/24/1930 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits Yes 2□No PGCapitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4219 Vine Street 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 53–55 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance U.S. Postal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edmondson Ada Lawrence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace A. Edmondson - Wife 4219 Vine Street; Capitol Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cemetery: 10/27/2008 Cheltenham, Maryland 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 21. Signatu 23a. Part 1. Enjer the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Inforution Mou co-did MISSINE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending

Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a been si certificate has be irector, page 2 sl director, ours after death neral Director: / filled in by the f

Physician

/Medical

Examiner

Physician/Medical \$ Be Completed Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a file filed Exx. virus must be realised and once.

Baltimore, Maryland 21215-0036

e Funeral completely within 2 To the Registrar

31. Date filed (Month, Day, State OCT 2 7 2008

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

0~

investigation

6 Could not be determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 10/19/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

grafts Rd. Clinton, Md 20735 15030 mederal

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Izola Mae Easley 14-13 October 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner County of Death 6 ever's If Under 1 Year If Under 24 Hrs. Social Security Number (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ☐ M 2 🔀 F Hours 05/02/1934 577-44-0787 Months Days Min Wash.,D.C. Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No D.C. Washington 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 5208 Dix St., N.E. 20019 U.S.A. by Funeral and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc.
African-1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: American 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Environmental Services Superv. Hospital h and Mental Hygie 7 is marked other t traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ellis Ethel Warren ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Crawley Easley/Husband 5208 Dix St., N.E., Washington, D.C. other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 10/24/08 Harmony Mem. Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licenses N. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bladde Immediate Cause (Final disease or condition resulting in death) **Physician** (ancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2.000 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Yes 2 □ No After this 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hosping within 24 hours after To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 2008 ss of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ROBERT T. FRAME 23 October 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore och Raven VA Rehab + Exkhded Care Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Days **Funeral** Months Hours 1 ₩ M 2 □ F 6/27/1919 Delaware Director 221-18-0683 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Funeral Director DE Sussex <u>Bridgeville</u> 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 4639 Hartzell 19933 United States Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give "natural", or Items 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify Completed by Year or Dates: • 41 – 58 White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Trucking Elementary/Secondary (0-12) Truck Mechanic 7 is marked other traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Treckle Charles W. Frame 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21632 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is m any injury or other traum once. 4953 Long Swamp Road, Federalsburg, MD Elaine Robinson/Friend Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/08 Federalsburg, Bethel Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD vale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung ancer /Medical Due to (or as a corresquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 12 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 24a. was an autopsy performed? 1∐ Yes 2,500 page 2 s certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner' Hospital: 1 ☐ Inpatient Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

OCT 2 4 2008

Wer

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD

3900

och

Raven Blvd, Bulto, MD 2/218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** October Marian Louise Frailey 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. . Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number **Funeral** 1□M 2XF 9,1913 **Director** 95 Pennsylvania 164-30-1671 Oct. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1X☐Yes 2☐No Hagerstown Directo Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21742 U.S.A. 1304 Pennsylvania Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No ģ If Yes, Give 3 Nidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental H f Item 27 is marked oth Be Anna Williamson Page Charles S. Page 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13815 Northvalley Dr. Hagerstown, MD 21742 Ann Conrad-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ment of H tant: If ite 20a. Method of Disposition Injury or 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any Injury or 11-8-2008 Montoursville, A Montoursville Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an ach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical leevery deseare Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 710 3 Probably 4 Unknown director, page 2 should Completed 24a. Was en 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to me examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 3 1 Impatient 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day, Year) 28c. Injury at Work? After t eath 28b. Time of 28d. Describe how injury occurred Hospital or Attending To the Hospital or Autoria 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Autural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier l 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 36655 use of death (Mem 23a) (1 200. HAGEN FORN, MD 21740

95H-5 State

31. Date filed (Month, Day, Year)

3 1 2008



Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ye ar OCTOBER Thelma В. Feick 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 X F Months 87 195-18-1821 July Director 1, 1921 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sl event, the Medical Examinar must be notified Director Washington Hagerstown 1 □Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10120 St. George Circle 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: 2 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ν. Baird George Blanche P Caseber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip G.A. Feick Son 346 Munntown Road, Eighty Four, Pennsylvania 15330 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ţ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Finleyville Cemetery 11-01-08 Ħinleyville, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, M<u>d. 21740</u> 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on fac ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Carcinoma mmediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar s a consequence of Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 res 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 **M**No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭UNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number မ MD D0041131 address of person who completed cause of death (Item 23a) (Type, Print) JERR CURRECES Opal Court Hagerstown MD 21740

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 17, 2008 **Physician** Marsha Ann Ford 9:49 Ам /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Community Hospital Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 1, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months 214-84-2321 46 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 1X Yes 2 ☐ No Funeral Director Glenarden Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9017 Glenarden Parkway 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Caregiver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Alfred Lincoln Ford Rose Marie Holley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeshia Holmes (Daughter) 9017 Glendarden Parkway, Glenarden MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department i Importent: If any injury or Arden Crematory 10/25/2008 Hanover, Maryland 21. Signature of Funeral Service trices 22. Name and Address of Facility Latimore Funeral Services, P.A. talricea umore 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE KENAL DISEASE **Physician** /Medical Examiner THROM BOCYTOFENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ▼ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) uneral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 □ Yes 2 □ No filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier completely and manner stated. 29c. License number 3 se of death (Item 23a) (Type, Print) HOSPITAL DR 3001 MICHAEL MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CORRY LEE FOREHAND tope 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S 1927 Year 927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 261-38-8859 80 Director DECEMBER 5 QUINCEY, FLORIDA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Wedical Exaction coust by confined at 10d. Inside City Limits Director 1 XYes 2 □ No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 TUNIC AVENUE 20743 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ X es 2 ☐ No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Xes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ģ Specify BLACK Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. any injury or other traumatic event, Inc. M. any injury or other traumatic event, Inc. M. any injury or other traumatic event, Inc. M. any injury or other traumatic event, Inc. M. any injury or other traumatic event, Inc. M. and injure. Elementary/Secondary (0-12) College (1-4or 5+) 4+ ACCOUNTANT TECH. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FOREHAND CALVIN ELLA SCOTT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA FOREHAND/WIFE 18 TUNIC AVENUE CAPITOL HEIGHTS, MARYLAND 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State GETHESMANE CHURCH: 10-18-08 4 ☐ Donation 5 ☐ Other (Specify) HUNTINGTOWN, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to minimum accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the burial-transit Exam and Due to (or as a consequence of): signed by the attending physician be detached for use as the buria certificate be Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Drostate 2 █ No 3 Probably 4 Unknown 1 ☐ Yes Completed peen ailure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2X No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. I of Vital Records, or Attending Physician; Division

altimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: completely filled in by the f To the Hospital

AMUE 31. Date filed (Month, Day, Year) State OCT 1 6 2008 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

m DD 60611

29d. Date signed (Month, Day, Year)

D 8118600d Luckld, Lanham, MD. 20706

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FULG YERAS **Physician** REMEDIOS 5:50 p M /Medical October 17,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hyattsville 7503 Wells Blvd. Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Philippines 1 □ M 2 🕽 F Director 70 Nov. 6,1937 220-70-1065 Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h. County 10d. Inside City Limits 1 Yes 2 No Director Hyattsville Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7503 Wells Blvd. 20782 U.S.A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Filipino 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Hampton, Delon & Assoc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susana Custodio Bive Fulgueras 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Doral Dr. Mitchellville, MD 20721 Wilfredo Fulgueras (brother) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Tanay Catholic Cemetery 10/27/08 Tanay Regal, Philippines 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2413 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FFMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 | Yes 2 | No 3 | Probably 4 Much Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 the 29c. License number 29b. Signature and title of certifie

Registrar

State

Name and address of perso

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Helen Fonville /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Plato Medica harle 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Engelhard, N.C. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 1 F Hours NP 416-76-7339 Director 11/25/1955 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examinar must be notified at Director 1 AYes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2503 Lake Drive items 23a 20602 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 10 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify Black ð Specify 3 ☐ Widowed 4 🔀 Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other tha any linjury or other traumatic event, Iranging in Jones. Home Health Aide Private Industry 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Stanley Barry Nove11a Howard ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendra Fonville / Daughter 342 Kingsborough 3rd. Walk #4F Brooklyn, N.Y. 11233 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🙀 Removal from State Cox Cemetery 10/26/2008 | Slocumb, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bronchiolita disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 hnknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performe certificate 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 1 1 No 1 [Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury After 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day, Year) death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Rd waldest, and 20002 enthan 3328 m-d oldwashing 31. Date filed (Month, Day, Year) State OCT 2 8 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 10c per fh 30 per dvr 885 11-12-08 vt State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		,	Cer	tificate of	Death		J	Reg. No.	2001	35	933
	Physicia		1. Decedent's Name (First, Middle, L JAMES EDWIN	T .	ALKENSTE	EIN				2. Date of Dea Month OVEMBE		6 20°	3. Time o	of Death A M
	/Medio Examin		4a. Facility Name (If not institution, g FREDERICK MEMOR		ΔL		4b. City, Town, o		of Death			County of Dea	ith	
	Funeral Director		5. Social Security Number 6. 220-16-0357 Usual Residence of Decedent	Sex 7. Age	e (In yrs. last bir 85	thday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Da Sept.25	h y, Yea <i>r</i>) ,192	C	rthplace (State ountry) yland	or Foreign
	yland or		10a. State 10b. County		10c. City, Towr	n or Loc	ation						10d. Inside C	City Limits
	e Mar Ba-f sh	ctor	Maryland Freder	ick	Free	leri	ek —	Myers	ville				1 □Yes	No 2√∑ No
	be filed within 72 hours after death with the Maryland ntal Hyglene. 9d other than "natural", or items 23a or 28a-f show event, if a Medical Examinar must be notified at	Funeral Director	10e. Street and Number 10208 Church Hi	ll Road			10f. Zip Code 2177	73			10g. Citi	zen of What C US	,	
_	items items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E		13. V	Vas Decedent of F Yes, specify Cub	lispanic Or an, Mexica	rigin? (Spec n, Puerto R	cify Yes or No- ican, etc.)		14. Race - Am Black, Whi		
0030	ours af		3 X Widowed 4 □ Divorced	1 ⊠Yes 2 □ N If Yes, Give Year or Dates:	43-46	1	□Yes 2√2 No	Specify.	:			Specify:	White	
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ana	e filed al Hyg I othel went,	Be C	17. Father's Name (First, Middle, Las	st)				18. Moth	er's Name ((First, Middle,	Maiden	Surname)		
Z Z	should be filed within 72 hours after and Mental Hyglene. s marked other than "natural", or ite umatic event, it a Medical Examina	ဥ	Walter Ray	Falkenstein					ottie	Marie		oman		
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e G	es 1 and 2 of Health of item 27 i fitem 27 i		20a. Method of Disposition	Пр	20b. Place of	Dispos	sition (Name of atory or other place	-	Da			cation - City or		
allimor	t. Pages tment of I tant: If ite		1 ☐ Burial 2 ∏ Cremation 3 4 ☐ Donation	oify)			g Cremat		lov.8,	2008	Smit	hsburg	, Maryl	and
ט ם	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.		21. Signature Funeral Service Oc	ensee 2			Name and Addre		•			n Stree		
			23a. Part 1. Enjer the disease, or co	mplications that caused	the death. Do r							TIE, M	D 21773 Approxima	te
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Ji.	/Medical Examiner		resulting in death)	Due to (or as a	a consequence o			1					1	
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0	rtificating phy as the	Medical	IL CELIALE:	0.										
ב ב	ath ce attendi for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnanc	у			2	23d. Date of de		Year
5	the de	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 ∐	Other (specify) _						Duy	Tour
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ב ה	has b	Completed	Xenit on	sufficient	ch					24a. Was a autop perfor	sy	24b. Were a prior to death?	utopsy findings completion of c	available cause of
<u> </u>	an: Th tificate tor, pay		25. Was case referred to medical	1	0			26 Place	a of Dooth	1 ☐ Yes	2 No	1 ☐ Ye	s 2 No	
-	hysici his cer I direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient	3 □ DOA Oth	er.				i □ Other (Spe	ecify)	
<u> </u>	Jing P	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. T <i>y, Year)</i> Ir	ime of njury	28c. Injur Worl			d. Describe h	ow injury	occurred		
	Atten r death sctor: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be 28e Place of Injur	ury - At home, far	rm, stre		Yes 2□		8f. Location (S	itreet and	d Number or R	ural Route Nun	nber,
5	Ital or rs afte ral Dire	Cert	4 ☐ Homicide determine	building, etc	c. (Specify)					City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should law the funeral director.	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best on the basis of aminer: On the basis of and manner sta	f examination and	, death d/or inv	occurred at the tile estigation, in my o	me, date ar opinion, dea	nd place, ar ath occurred	nd due to the	cause(s) date and	and manner a place, and du	s stated. e to the cause(s	s)
	To the comp	Me	29b. Signature and title of certifier	al 1)	29c. Licens	e number		- 4	29d. Date	e signed (Mon	th, Day, Year)	
			X shuld.	1 serfm	nun	m	D. D-	-/39	7/		14	16/0	5	
	1		30. Name and address of person who Robert L. Kaufma				rint) reet Fr	odo z :	ck M	d 217	N 1			
	Stat	te	31. Date filed (Month, Day, Year)		ar's Signature	الا السيد	reet FI	CUELL	CA PI	4. 41/	V1			
	Registra		NAV 1 2 2	2008	J.		1 Page 3							
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24,2008 Cleveland Gaskins October 14:10 4a. Facility Name (if not institution, give street and number)
Prince Georges Hospital 4b. City, Town, or Lor Cheverly City, Town, or Location of Death Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07/12/1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 250-18-9695 1₽M 2□ F Months sc Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Capitol Heights 10b. County Prince George's 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 134 Maryland Park Drive 10f. Zip Code 20743 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □ No If Yes, Give Year or Dates Specify: Specify: Black 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th grade College (1-4or 5+) Laborer LaPorte' 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Executation to rediffed at once. Be Completed

Physician

/Medical

Examiner

10a. State

MD

Director

by Funeral

Funeral

Director

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran certificate has been signed by the rector, page 2 should be detached this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

ב ב	Oliver Gaskins					Jan	ie	Cunn	ing	ham	l		
	19a. Informant's Name/Relationship (Ty Sadie Smith/Dau	_{pe.Print)} ghter	693	Mailing Addres 88 Eme	ss (Street ISON	and Numb St	ber or l ∙ Hy	Rural Route atts	Vill	er, City o	r Town	2 0 7	Zip Code) 7 8 4
	20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		cemetery	Disposition (No.), crematory or NY Mem	other place	re)	11/	Date /1/20	80			-City or Ver	Town, State MD
	21. Signature of Funeral Service License	e de la como		22. Name Dunn&	and Addre Sons	ss of Faci	3 ^{lity} 5	Eads	St	. N	E	Va St	jagton, Do
	23a. Part. Enter the disease, or compli book, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the ne cause on each line. Acute			•	ıg, such a	s cardi	iac or respi	ratory a	rrest,			Approximate Interval Between Onset and Death 2 Weeks
	Sequentially list conditions	Due to (or as a consequence of): Gastrointestinal Bleeding									1 week		
Yallili V	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						w.1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -					12/17/20
	, osaming in assauly East	L	onsequence of										
yololaliying	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ☐ Ectopio 5 ☐ Other (у						ate of del	livery Day Year
, A	Part II. Other significant conditions con Thrombocytopen		ot resulting in	the underlying	cause giv	en in Part	1.	23					the cause of death?
ombiere	Coronary Arter Respiratory Fa		5				-	-	a. Was autor perfo			prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 11 Inpatient	2 ER/Out	patient 3 🗆 [OOA Oth			eath (Chec	k only o	ne)			
	27. Manner of Death 12 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury Wo			28c. Injur Worl	her: 4 Nursing Home 5 Reside jury at ork? 2 No 28d. Describe hor		now injui	ow injury occurred				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, fari Specify)	m, street, facto	ry, office	nile				Street ar vn, State		ber or Ru	ural Route Number,
The state of the s		sician: To the best of n ner: On the basis of ex and manner stated	amination and										

State Registrar

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revathy Murthy 6130 Landover Road Cheverly MD

32. Registrar's Signature

29c. License number

D16273 MD

29d. Date signed (Month, Day, Year)

4/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Shelby E. Griffin 10 18 2008 1:13A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 K Months Days Hours Min. 71 242-52-4879 05/19/1937 Usual Residence of Decedent 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 1X Yes 2 No Prince George's MD District Heights 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2140 Brooks Drive, #211 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛚 No **Black** If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tape Librarian NASA/Space Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Dixon Annie Reid 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Griffin/Husband 2140 Brooks Dr., #211, District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/08 Arlington National Arlington, VA 21. Signature of Funeral S 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rulmoren Chance Obstrutive disease or condition resulting in death) Due to (or as a consequence of): Promonie Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "section learn man to make

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exercises

Physician

/Medical

Examiner

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To the 1

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director

Baltimore, Maryland 21215-0036

Exami Physician/Medical Completed Be Medical Certification: To 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10/20/08

علو State

Registrar

31. Date filed (Month, Day, Year) OCT 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

mani 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 10/20/2008 4:25 a Elnora Graves /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 43 Featherwood Court If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 E F Yrs 12/12/1925 VA Director 231-22-0876 82 Usual Residence of Decedent with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 20904 United States 43 Featherwood Court filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black \$ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private and Mental Hygie Is marked other Department of Health and Menter Important: If item 27 Is any Injury or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elnora Barnes John A. Spratley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5206 berkshire Dr. Hopewell, VA. 23860 Emily Graves / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Sinai Cemetery | 10/25/2008 | Prince George, VA 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licens 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1 Epres the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vehy dration /Medical Due to (or as a con equence of) Examiner metastatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): he lay requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a 0 1 ☐ Yes 2 🔯 No 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Tyes 2 No 3 Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an pade 2 s autopsy performed certificate 1∐ Yes 2√ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director: A r filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B 0061896

Registrar
DHMH 17 Rev 1/2001

State

12201 Plum Orchard Drive Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Anuradha Dahlya

31. Date filed (Month, Day, Year)

OCT 2 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				artment of Health and Mental rtificate of Death	Reg. No. 2001	8 35937
	Physicia		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Terry Wayne Harbaugh	Mgnt	of Death h Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	ath
_	Francis		Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date	Washing	_
	Funeral Director		220-58-4717 1⊠ M 2□ F 57 Yrs.	Months Days Hours Min. (Mon O2/	of Birth th, Day, Year) 9. Bind 11/1951	irthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	Maryli Ff sho	tor	MD Washington Hagers			1⊠Yes 2□No
	h with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 7 E. Washington Street	10f. Zip Code 21740	10g. Citizen of What C	Country?
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Eventher must be neithfield at	by	11. Marital Status 11. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 11. Yes 2 No If Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☒ No Specify:		
21215-0036	ithin 72 ho ne. nan "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business	•
22	iled wi Hygier ther th	Ç	17. Father's Name (First, Middle, Last)	Laborer 18. Mother's Name (First, N	Brickya	ra
an	Ild be f fental rked or tic eve	To Be	William Edward Harbaugh	Clara Ida		
, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type. Print) Louise O. Harbaugh / Aunt 19b. Maili 952 I	ng Address (Street and Number or Rural Route I Lanvale Street, Hagerst	Number, City or Town, State, LOWN, MD 21740	Zip Code)
Baltimore,	ges 1 at of He If Item or oth			osition (Name of Date matory or other place)	20c. Location - City o	
	nit. Pa artmer ortant: injury			g Crematory 10/30/200 2. Name and Address of Facility Gerald		
ä	Per a proper			305 N. Potomac Street,		100000000000000000000000000000000000000
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		tory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			<u> </u>
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			to en
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Ď,	rtificate be executed og physician and as the burial-transit	ledical Examiner	resulting in death) Last Due to (or as a consequence of):			
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7.	s that ined by e detail	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e.	Did tobacco use contribute	to the cause of death?
cords	e law requires that the d has been signed by the e 2 should be detached	ted b	Capranic Fredux L-1 Fred		1 ☐ Yes 2 ☐ No 3 ☐ F	Probably 4 4 Unknown
L Rec	The law requires that the ate has been signed by the page 2 should be detached.	Completed	Som Ancity Aut Rend Fair		autopsy prior to death?	autopsy findings available completion of cause of
VITAL	Physician: r this certific ral director, p	Be	25. Was case referred to medical	26. Place of Death (Check	only one)	
5	ding Physician: The n	음	1 ☐ Nos 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time o		Residence 6 Other (Sp	ecify)
SION	tending leath. tor: Afte the fune	atior	1 □ Natural 5 □ Pending (Month, Day, Year) Injury 2 ☑ Accident investigation (S & S S S S S S S S S S S S S S S S S	Work? FELL	3 FF 350 F	117 4CAD
	ar or Affe s after de al Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)		ion (Street and Number or For Town, State) 351 Ed	Sural Route Number, Sr Annetan St.
:		edical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deat 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due	o the cause(s) and manner	as stated.
İ	within Com.	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
	45	-	To Name and address of passes who completed against the Man 2001 True	DISOIS DOUSER	65 00 29	2008
-/	2		_	MILL ST MAGER	stown, m	0 21740
	Stat Registra	e Ir	31. Date filed (Month, Pay, Year) 2008 32. Restrar's Signature	L. H.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 OCTOBER 4:47 P GLORIA I. HOLMES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y AUG. 29 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours Min. $^{(ar)}$ 1940 | WASHINGTON, DC 1 □ M 2 🕅 F AUG. 68 579**-**54-8714 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 XYes 2 ☐ No PRINCE GEORGE'S UPPER MARLBORO MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17244 BROOKMEADOW 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 📉 No BLACK If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12TH CORRECTIONAL OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **KEYS** LUCILLE RICHARD HOLMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17244 BROOKMEADOW LANE UPPER MARLBORO, MARYLAND VERONICA S. HOLMES/SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗹 Cremyation 3 🗆 Removal from State RESURRECTION CEMETERY 10-25-08 CLINTON, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Fuseral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic disease or condition resulting in death) 47 Knows bulmonay Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events delivery Day Year e to the cause of death?] Probably 4 Unknown autopsy findings available to completion of cause of 2 X No /es Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached funeral director, After this

Physician

/Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed by

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Physician/Medical Examine

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Be Completed

resulting in death) Last	Due to (or as a consequence	of);	
•	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of Month
Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribut
			24a. Was an autopsy performed? deat
25. Was case referred to medical		26. Place of De	eath (Check only one)
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/O	outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) on	Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 Cuitoido 6 Could not	ne l		

Certification: To within 24 hours after death

To the Funeral Director:

Spmpletely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAR

08-07647	
Joseph C.	Harrell

oseph C. Harrell	State of Maryland / Department of Maryland / Department of Certificate of Registrar	of Death	eg. No. 2008 3593
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month October 1	th 3. Time of Death
	4a. Facility Name (if not institution, give street and number) 4500 Silver Hill Road	4b. City, Town, or Location of Death Suitland	4c. County of Death Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		th(MM/DD/YYYY) 9. Birthplace (State or
Director	579-17-5619 1X M 2 F 20 Y	rs. Months Days Hours Min. 8/26/	/1988 ForeignWashington,
ow any	10a. State 10b. County 10c. City, Town or Loc Washingto		10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show tified at once.	10e. Street and Number		0g. Citizen of What Country?
with the Maryland ms 23a or 28a-f sho be notified at once.		Was Decedent of Hispanic Origin? (Specify Yes or No	
er death with , or items 23		f Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:	White, etc. Black Specify:
hours after the state of the st	or Dates:	lent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour hygiene. other than "nate the Medical Exal	Elementary/Secondary (0-12) College (1-4 or 5+) +2 Docum	nent Coder	Private
21215-0036 Julid be filed within 7 Mental Hygiene. marked other than e event, the Medica	Joseph Harrell, Jr.	18.Mother's Name (First, Middle, Afrecia Day	
and 2 should feath and Me tem 27 is ma traumatic even	19a. Informant's Name/Relationship (Type, Print) Joseph Harrell, Jr (Father) 19b. Mail 2514	ling Address (Street and Number or Rural Route Nur 18th Street NE Washing	nber, City or Town, State, Zip Code) ston, DC 20018
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once To Re Commised by Firmeral Director	1 Ruriol 2 V Cromation 3 Removal from State crematory or	position (Name of cemetery, Date other place) accin Crematory 10/20/200	20c. Location - City or Town, State
Baltimore, permit. Pages 1 and Department of Healt Important: If item injury or other tra	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22	Name and Address of Facility Fort Linco	oln Funeral Home
ம் இத்தித் Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	8401 Bladensburg Rd. Brer er the mode of dying, such as cardiac or respiratory are	
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death
i d	Sequentially list conditions, b		
red nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
60, ate be executed hysician and burial - transit	d. DUNPENDED AMENDED		
760, ficate be execut g physician and the burial - tra		Fuel days 2 Fetenia propagati	23d. Date of delivery Month Day Year
Box 6876(e. death certificate the attending phy defor use as the by	past 12 months?	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Teal
P.O. B that the d	Part II. Other significant conditions contributing to death but not resulting in the		obacco use contribute to the cause of death? s 2 ✓ No 3 Probably 4 Unknown
ords, F w requires is been sign should be		24a. Was	an 24b. Were autopsy findings available
tal Records, cian: The law requires certificate has been signated by the Completed Be Completed	E C	perfo	ormed? death? 2 No 1 Yes 2 No
f Vital Rec Physician: The I er this certificate I ral director, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one) ent 3 DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
on of anding Plant. The funera	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) Oct 10, 2008 1154 hrs		how injury occurred apped in front of a train and struck by
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th rours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Metro train tracks	treet, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State) Hill Road, Suitland, Md.
bou bou		curred at the time, date and place, and due to the cau	ise(s) and manner as stated.
To the He within 24 completely	2 Medical Examiner on the basis of examination and/or investi- and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
(4)	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	October 11, 2008
HC	Ling Li, MD Assistant Medical Examiner 111 Penn Str	reet, Baltimore, MD 21201	
Stat			'į-

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 KEVIN BRYANT HINES 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cheverly Prince Georges Hospital Prince Georges 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Davs Hours Min. **1** M 2□F Months 214-72-3473 50 12, 1957 Washington, D.C Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No Maryland Prince Georges Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2212 Alice Ave. 20745 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Tx Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Postal Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ervin Hines Fairey Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justine B. Hines/ Wife 2212 Alice Ave. #2 Oxon Hill, Md. 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/22/2008 Resurrection Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope. P.A. 5538 Marlboro Pike/ Forestville, Md. 21. Signature of Funeral Service Licensee 20747 CLASP 040/085 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ENCEPH ALOPATH Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): PICENSE END STAGE Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACQUIRED MEFICIENCY IMMUND Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 2 No 9□Unknown

23e. Did tobacco use contribute to the cause of death?

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed? Yes 2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 TYes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

2 □ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

a or 28a-f show t be notified at

items 23a

'natural", or

Pages 1 and 2 should be filed inent of Health and Mental Hygicint: If item 27 is marked other

permit. Pages 1 Department of H Important: If ite

injury

any in

Examiner must

Director

Funeral

þ

Completed

Be

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

and aftending physician the as nse Į the detached peen has page 2

certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine certificate

After this within 24 hours after death To the Funeral Director;

þ Completed Be P Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

9 ☐ Unknown

1 ☐ Yes 2 X No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

Physician/Medical completely filled in by the **Medical**

5 State

death.

Hospital or

P	M	B	REE	N	
31.	Date	filed	(Month,	Day,	Year
			00	T 2	n

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE GED RGES 405 PITM

1 💢 Inpatient

28a. Date of Injury (Month, Day Year)

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

00067810

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

08-07886 Irene Holloway Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ne Holloway	State of Maryland / Department of Certificate of Certificate	f Health and Mental Hygler f Death	Reg. No.
Physician/ edical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) IRENE HOLLOWAY		e of Death th Day Year ober 20, 2008 3. Time of Death 0636 hrs
Funeral	Prince Georges Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	4c. County of Death Prince George's ate of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign SOUTH County) RIL 2 1925 County
Director	579-38-1624	•-	10d. Inside City Limits 1 X Yes 2 No
AD 21215-0036 2 should be filted within 72 hours after death with the Maryland and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any unatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 401 CHAPLIN STREET S.E. # 401 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	10f. Zip Code 20019 as Decedent of Hispanic Origin? (Specify Y	10g. Citizen of What Country? USA (es or No- 14. Race - American Indian, Black,
rs after death with thurs?, or items 23a miner must be not by Funeral I	1 Never Married 2 Married Armed Forces? If 1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year or Dates:	Yes, specify Cuban, Mexican, Puerto Rican, Yes 2 X No specify: ent's Usual Occupation (Give kind of work do	Specify: BLACK
5-0036 sed within 72 hours tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs SEAMS	most of working life. DO NOT use retired) STRESS 18.Mother's Name (First,	PRIVATE , Middle, Maiden Surname)
ID 21215-0036 should be filed within 72 and Mental Hygiene. 27 is marked other than matic event, the Medical To Be Comple	REV. JAMES DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailli		Route Number, City or Town, State, Zip Code) 20745
s 1 and of Healt If item	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specific	osition (Name of cemetery, other place) TION CEMETERY 10-27-	-08 CLINTON, MARYLAND
Baltimo permit. Page Department Important: injury or of	21 Signature of Funeral Service Licensee 22.	474 TANDOVER ROAD LA	3. JENKINS FUNERAL HOME ANDOVER, MARYLAND 20785 iratory arrest, shock, or heart ascular disease Approximate Interval Between Onset and
'Medical .aminer	Immediate Cause (Final disease or condition resulting in death) a. associated with head Due to (or as a consequence of):	ad injuries	Death
ed nsit Evaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
O, be executed sician and burial - transit		Ba-f, perME G885 11/	13/08 TT
Box 68760, death certificate be executed the attending physician and ed for use as the burial - transit	23b. Was decedent pregnant in the past 12 months? TFEMALE: 23c. If yes, outcome of pregnant of the past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
he d	Diabetes mellitus	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ords:			24a. Was an autopsy performed? 1 V yes 2 No 1 V yes 2 No
of Vital Recling Physician: The I	25. Was case referred to medical examiner? 1	of Injury 28c. Injury at Work? 28d.	
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	Natural 5 Pending Investigation 2 X Accident 3 Suicide 6 Could not be determined 4 Homicide Find 10/19/08 Find 10/	treet, factory, office building, etc. 28f.	Location (Street and Number or Rural Route Number City or Town, State) 401 Chaplin St, S.E ashington, D.C.
Divis To the Hospital or A within 24 hours after (To the Funeral Direc completely filled in by	Certifying Physician: To the best of my knowledge, death of (Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	igation, in my opinion, death occurred at the	to the cause(s) and manner as stated. etime, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	hy hu, no	29c. License number O.C.M.E.	October 21, 2008
(L) Sta	22 Penistrar's Signature	reet, Baltimore, MD 21201	

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

State

Registrar

OCT 2 1 2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 17 2008ar MILDRED D. HARLEY 12:56 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 931 Months Days Min. Hours 1 □ M 2√□ F WASHINGTON DC 578-38-2487 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show Director 1 √Yes 2 No MD PRINCE GEORGE'S CLINTON 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 9708 DALMATIA DRIVE 20735 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian "natural", or item Armed Forces?

1 Yes 2 Mo
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No BLACK Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA MANAGER GOVERNMENT 7th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN W. FLETCHER SARAH L. STEWART ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE HARLEY/HUSBAND 9708 DALMATIA DRIVE CLINTON, MARYLAND 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 □ Donation S □ Other (Specify) MD VETERANTS CEMETERY 10-24-08 CHELTENHAM, MARYLAND 21. Signature of Fureral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neart **Physician** Lachemie /Medical Admitted Due to (or as a consequence of): Examiner Stage 91(08 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Siabetes g physician and is the burial-trans Due to (or as a consequence of) 10/17/108 at Box 68760. Physician/Medical Peripheral 1305 6m IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Year Day 5 ☐ Other (specify) Division of Vital Records, P.O. this certificate has been signed by the al director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2. 2.No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of spital or Attending Phours after death, neral Director; After ty filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 35295 10.17.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATISH JUMANI, M.D. Prive, Svik 208, Worldorf MD20603 10 St. factricles 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 1 ZUUG Registrar

3	0	(rent	0	1	1
4	- %	\sim	14	1.1	1
2	142	U	1	Y	

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Day

Year

1 Yes 2 No

Reg. No. 2. Date of Death 3. Time of Death Month Day Thomas Henderson 30PM 212008 tobe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Year) March 3, 1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 AM 2□ F Months Days Hours Min. 247-42-0068 77 South Carolina

Funeral Director

/Medical

Examiner

the Maryland with death

HENDERSON, THOMAS

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exart with ust on notified at Director Funeral <u>م</u> Completed Be

Maryland 21215-0036 and Mental Hygi If item 27 Is other altimore, Pages 1 Department of Important: If it any Injury or o **Physician** /Medical

Examiner

law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, P.0. cate has been signed by the page 2 should be detached Division of Vital Records, certificate l

\$

Completed

Be

Certification: To

Medical

in the past 12 months?

25. Was case referred to medical

examiner

4 ☐ Homicide

(Check only one)

OCT 23

29a. Certifier

1 □Yes 2 □ No.

funeral director, After this To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Maryland Prince George's Glenarden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7937 Fiske Avenue 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Will Henderson Victoria Ellis ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Triplin - Daughter 523 Pennsylvania Ave. Fairmont, WV 26554 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemt. Oct 25, 2008 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 14001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, concert failure. List only one cause on each line. Immediate Cause (Final ardio respiratory disease or condition resulting in death) Due to (or as a consequence of): ina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Respiratory resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. No 1 Yes 2 No 1 □Yes 26. Place of Death (Check onl one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

3 Ectopic pregnancy

5 ☐ Other (specify)

1 Yes 2 No 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number MDD 58976 october 22 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Nima H. Calaf, MD P.O. BOX 297, Greenbelt, MD. 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 2008 Grover D. Hawkins 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death

Months

10f. Zip Code

20785

7. Age (In yrs. last birthday)

70 Yrs.

10c. City, Town or Location

Landover

Chever1y

Days

If Under 1 Year | If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Min.

11:25A^M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 □ No

Prince George's

14. Race - American Indian,

Black. White, etc

Specify: Black

10g. Citizen of What Country?

USA

Date of Birth (Month, Day, Year) 09/20/1938

Physician /Medical Examiner

Funeral

Prince George's Hospital

10b. County

8626 Reicher Street

1 X M 2 □ F

Prince George's

5. Social Security Number

10e. Street and Number

11. Marital Status

10a. State

MD

Director

238-58-9361 Usual Residence of Decedent

Director show ed other than "natural", or items 23a or 28a-f show event, I're Medical Exeminer must be notified at

signed I has page 2 s certificate within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. To the within 2

Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No within 72 hours after 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Machinist permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important; If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Odell Richardson Andrew Hawkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie M. Hawkins/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/2008 4 Donation 5 ☐ Other (Specify) Lincoln 22. Name and Address of Facility 23a. Pal-1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each li Immediate Cause (Final **Physician** HILLER disease or condition resulting in death) /Medical Due to (or as a consumence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 Completed 24a. Was an Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manyrer of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 3 ZUUG

James Catevenis, 3001 Hospital Dr., Cheverly, MD

32. Registrar's Signature

8626 Reicher St., Landover, MD 20785 20c. Location - City or Town, State Brentwood, MD Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Yes 2 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

20785

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2026 Elizabeth Harrington 10 2008 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Regional 34/156414 HICOMICS If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 💢 F 82 8-11-1926 201-18-3124 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Tressler Drive 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Bookkeeper Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Homan Grace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Harrington - Son P.O. Box 209, Fruitland, Maryland 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10-27-2008 Delmar, Delaware Crematory of Delmarva 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part . Enter the disease, or con shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or comp Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): 5/14/5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Marileo Examination of the fraumatic event

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran

alE	
an/Medica	IF 2
Be Completed by Physician	Pa
oleted by	-
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Certification:

Medical

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of	f Death (Check onl one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursi	ing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of String of St	28d. Describe how injury occurred
3 Suicide 6 Could not determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of my knowledge, death occurred at the time, date and aminer: On the basis of examination and/or investigation, in my opinion, death	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)

29c. License number

42995

100 E. CARROLL ST. SALISBURY MD

29d. Date signed (Month, Day, Year)

10-24-2008

State Registrar

C

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Cutcheon

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



				Department of Health and N Certificate of Death	
			Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death
	Physic /Medi		FloRence Isperson		Month Day Jove 1235 A
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
			Anchorage nursing Home	SALBURY	WKOMico
	Funeral Director		5. Social Security Number 6. Sex 1	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1111inois
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Toy	vn or Location	10d. Inside City Limit
	/anyli	ō		ntico	1 ☐ Yes 2 ∑x N
	288-	rect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	within 72 hours after deeth with the Maryland ane. The north and thems 23a or 28a-f show them and the notified at the Madical Expirition must be notified at	Funeral Director	5438 Sandy Hill Rd	21856	USA
	deeth	Jera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	necify Yes or No. 14. Race - American Indian,
· ·	or Its	F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 No		
03	ours Fra	d by	3 ★ Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: white
4	72 h	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/Industry
5	of his	E I	Elementary/Secondary (0-12) College (1-4075+)		
Š	lled y		12 2 aC	ministrator	church e (First, Middle, Maiden Sumame)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the readment of the Medical Expaniture must be notified at ancie.	To Be	Howard Knolton Adams	Esther	r Ouimette
2	and 2 sh salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Linda R. May/daughter	o. Mailing Address (Street and Number or Run 606 Irene Ave., Salis	al Route Number, City or Town, State, Zip Code) sbury, MD 21801
Raltimore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	of Disposition (Name of arry, crematory or other place)	Date 20c. Location - City or Town, State
<u>Ē</u>	Pag ment ant: I ury o		1 E Bandi 2 E Gromation 5 Enternovariion State	oury Crematory 10/24	4/08 Salisbury, MD
7	permit. Depart Import eny inj once.		21. Signature of Funeral Service Licenses	Holloway Funeral Ho	ome Professional Association
<u>.</u>	20559		1 Leland	501 Snow Hill Rd.,	Salisbury, MD 21804
Wiconia)	Physician /Medical Examiner permal-transll permal-transl	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infill educate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last Due to (or as a consequence or injury that infiltated events resulting in death) Last	1 <u>115</u> or):	Interval Between Onset and Death
0 C+299	t the death certification by the attending place in use as t	Physician/Medic	d	5 ☐ Other (specify)	23d. Date of delivery Month Day Year
# S		2	Part II. Other significant conditions contributing to death but not resulting in COUD N CK		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknow
Reco	The law requirate has been sipage 2 should	Completed	,		24a. Was an autopsy performed2 24b. Were autopsy findings available prior to completion of cause of death?
a	iicien: Th certificate rector, pag	Ö	25. Was case referred to medical	00.81	1 Yes 2 No 1 Yes 2 No
5	ysicien: is certific director,	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Other	h (Check only one)
Division of Vital Records	Attending Physicien: or death. ector: After this certifics by the funeral director,	atlon: T	27. Mann of Death 28a. Date of Injury 28b.		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Divis	al or Attendi s after death. Il Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge of examination are and manner stated.	e, death occurred at the time, date and place, id/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	To the I	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	SIM		30. Name and address overson who completed cause of death (Item 23a)	(Type, Print) 504B	MD 21804
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 8 2008 32. Registrar's Signature	Snadi ,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Louisa Izzo 4:00 a^M Mae October 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Delmar Wicomico 9222 Green Isle Circle If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) 1 ☐ M 2 🍎 F Months Days Hours Min. 221-24-1407 70 8/10/1938 Delaware **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Delmar Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21875 USA 9222 Green Isle Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ج white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Certified Nursing Assistant Health Care 9 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite Pearl Cooper unknown Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9222 Green Isle Circle, Delmar, MD 21875 19a. Informant's Name/Relationship (Type, Print)
Fred L. Izzo, Sr./husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 10/28/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer se HOTTOWAY FUNERAL Home, Professional Association any Kertb Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician erdisease or condition resulting in death) COM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) 68760. Physician/Medical attending ph for use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify). signed by the a Ö 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1/√√Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate 1 ☐Yes 2 Z No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred ospital or Attending hours after death. 14 Natural 5 Pending within 24 hours after uccommon to the Funeral Director. Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1004500 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 346 1. l 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registra OCT 28 2008

08-08159 Heather A. Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 35949

		1- For State Registrar		Certific	ate of	Death			Reg. No.		
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle						2. Date of De Month	Day	Year	3. Time of Death 0700 hrs
Todical Exami		Heather A 4a. Facility Name (if not institution			46	. City, Town, or Lo	ocation of Deati		31, 2008 4c. Co	unty of Death	
		700 Moores Ave				Cambridge			Dore	chester	
Funeral		,	S. Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24Hrs		Birth(MM/DD/	YYYY) 9. Biri Foreig	thplace (State or
Director			1 M 2 🔀 F	33	Yrs.	Months Days	Hours , Will		08-19		untry) Md.
any		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Locatio	n					10d. Inside City Limits
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after death with the Maryland al", or items 23a or 28a-f sho iner must be notified at once.	Director	10e. Street and Number iley	Rd.			10f. Zip Code			10g. Citizen	of What Cour	ntry?
ith the		608 Bradle	12. Was Decedent E	ing in II C	112 18/00	21613 Decedent of Hispa	ania Origina (C		USA	Dana Amori	can Indian, Black,
eath w	Funeral	1 Never Married 2 Mar	Armed Forces?	No No		s, specify Cuban, I			14.	White, etc.	carrindian, black,
고 5 티	by Fi	3 Widowed 4 Divo	rced If Yes, Give Year or Dates:	NO NO	1 \	res 2 X No	specify:		Spe	ecify: Bla	ack
hours.		15. Decedent's Education (Speci	fy only highest grade comp			Usual Occupatio			16b. Kind	of Business/I	ndustry
36 in 72 in dical	Completed	Elementary/Secondary (0-12) 1 0	College (1-4 or 5-	+)	-	emaker)wn ho	
5-0036 ed within ygiene. other tha	Som	17. Father's Name (First, Middle, I	Last)		11011		3.Mother's Nam	e (First, Middle			nie -
21 be fi	Be (Edward	Dorsey				Garr	ett ·	Smell	in S	Smullin
ID 21 should and Mer 77 is man	P	19a. Informant's Name/Relationsh Leroy Jones,		1.0		Address (Street			-		
Z 2 d a a a a a a a a a a a a a a a a a a	10	20a. Method of Disposition	SI./ nusbai	20b. Place	of Dispositi	on (Name of ceme	eterv.	Date	200 100	ation - City or	. 21613 Town, State
altimore, MD 2 mit Pages I and 2 shou partment of Health and I portant: If item 27 is r ury or other transmatic		1 Keurial 2 Cremation		e Waug	tory or other	rplace) apol Co cematory	m 11	Date 18 - 13 -0	8 Cam	ver, I brida	Deleware e,Nd.
- E - B - E -	1	4 Donation 5 Other Spe 21. Signature of Fund Service L		Direc	22. Na	rematory me and Address o	PPO				
Ball permit Depart Impor	K	assime	1 John	NA -	52	4 Race	St. Ca	mbrid	ge,Md	.2161	ral Home
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3760, ficate be executed g physician and s the burial - transit		Lunennes	d10a	10 200		- fb 22a	TT	27 70	T TO 0	996	
30, te be e	n/Medical	X UNPENDED	x AMENDED 10e 3 23c. If yes, outcome			1 III,23a	, pt. 11,	. z / pe		ate of deliver	1
ω	an/N	23b. Was decedent pregnant in the past 12 months?			2 Feta	I death 3	Ectopic pregn	ancy			Day Ye ar
Box 6 e death ce the attend	Physicia	1 Yes 2 No 9 ✔ Unkn	4 Pregnant at ti	me of death	5 Othe	er (Specify)			ï		
~ € & 5		Part II. Other significant condition		but not resultir	ng in the un	dertying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
S 25. 8	Completed by	Chronic Alco	ohol Use					1 Y	es 2 🗸 N	o 3 Prot	pably 4 Unknown
of Vital Records, Ing Physician: The law requires ther this certificate has been signeral director, page 2 should be	lete							24a. Wa	s an opsy		topsy findings available completion of cause of
The law ate has age 2 s	E O					_			formed?	death?	
	Be	25. Was case referred to medical examiner?					of Death (Check	only one)			
F Vit	P	1 Yes 2 No	Hospital: 1 Inpatien		Outpatient	- La.		ng Home 5			r: Scene
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Division tal or Attendin is after death all Director:	ertification:	2 Accident Invest	gation	ry - At home, f	arm, street			28f. Location	(Street and	Number or Ru	ral Route Number, City
Divisi pital or At ours after d reral Direct filled in by	je i	3 Suicide 6 Could determ	not be inned (Specify)					or Town	State)		
Division of Vital To the Ilospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director,	ical C		vsician: To the best of my iner:On the basis of exam								
To T	Medical	29b. Signature and title of certifier	and manner stated.		-	29c. License		-,			nth, Day,Year)
		Dr- my) Limo			O.C.M	.E.		Octobe	er 31, 200	8
	f	30. Name and address of person v	ho completed cause of de			<u> </u>	D-10:	1D 0100:			
	ate	Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Medica		111	Penn Street, E	saitimore, N	21201 טוי			
Regist	_	NOV 0 7		J J	Mari	W					

	1	For State Registrar	State of Maryl		irtment of F tificate of i			giene	8 35950
Di di di	_	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
Physiciar /Medica	-	Mark Anthony Je	ewett					22, 200	
Examine	-	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	r Location of Death		4c. County of	
		Calvert Memorial				Frederick			1vert
Funeral Director		214-58-1280	_	yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day October	(Year)	9. Birthplace (State or Foreign Country) District of Colum
me 23e or 28a-1 ehow	-	Usual Residence of Decedent 10a, State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
Department of Health and Mental Hygiene. Important: if Item 27 I e marked other then "neturel", or iteme 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.	5	Maryland Calvert		Lusby					1 ☐ Yes 2X No
noth	2	10e. Street and Number		шазоу	10f. Zip Code		1	10g. Citizen of Wh	nat Country?
300	2	12812 Rousby Ha11	Road		20657		1	United S	tates
r iteme 23a or 28a-f e niner must be notified	5	11. Marital Status	12. Was Decedent Ever		Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		- American Indian,
2番		1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			an, Mexican, Puerto Specify:	rican, etc.)		White, etc.
Exa	ב ב	3 Widowed 4 Divorced	Year or Dates:		I∐Yes 2MX No	Зресну.		Specify:	White
it, the Medical	20 0	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occup kind of work done	during most of work	ang	16b. Kind of Busi	iness/Industry
4	<u>.</u>	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	1)		D 1 1 1	~
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2	ŏ		-11					Maideri Surname,	
age 1	2 -	Monroe Allen Jew 19a. Informant's Name/Relationship (Ty)		10h Mailie	- Address (Street		Thomas	. City as Town C	tota 7i- Codel
traur				100		and Number or Rui			
the a	-	Joyce Jewett-Floyd 20a. Method of Disposition		b. Place of Dispo	sition /Name of	nt Rd., S	Date		MD Z10Z0 ity or Town, State
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E de .	-	4 Donation 5 Other (Specify)			n Crematory				a, Virginia
eny It		21. Signature of Funeral Service License	H C			ss of Facility Ra		cal Home,	P.A.
	+	23a. Part1. Enter the disease, or compli	Harden)			00, Lusby,			Amerovimeto
4		snock, or near failure. List only or	ne cause on each line.	ath. Do not ent	er the mode or dyin	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
sician		Immediate Cause (Final disease or condition resulting in death)	MYOC	ARDIA	LINF	ARCTIC	1 N		minutes
dical niner		Toolking in doubly	Due to (or as a cor	sequence of):					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con						many years
) Sit		cause. Enter Underlying Cause (Disease or injury	11	isequorico orj.					200
rial-transit	7	that initiated events cresulting in death) Last	Due to (or as a con	sequence of):					many years
the burial-transit	5								
s the	5								
leteched for use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre	egnancy				23d. Date	of delivery
- To	2	in the past 12 months?	1☐Live birth 2☐I 4☐Pregnant at time		Ectopic pregnancy Other (specify)	,		Monti	,
chec		9 Unknown	9□ Unknown						
ag a		Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ם ב	2	GERD HYPE	RCHULE	STROL	EMIA	COPD	1 1	es 2 □ No 3	☐ Probably 4 ☐ Unknown
snor		LUMBAR D					24a. Was a	n 24b We	ere autonsy findings available
page 2 should be c	<u> </u>		11 5(30	U 2 C			autops	med? de	ere autopsy findings available or to completion of cause of ath?
io io		25. Was case referred to medical				00 011 0			Yes 2 ANO
direct.	3	examiner?	ospital:	2 R/Outpatien	Oth	er:			(0
eral o	- -	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun			ence 6 Other	
£ 5		1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury		k? Yes 2 □ No		, ,	
led in by the funera	2	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - /	At home, farm, stre	et, factory, office		28f. Location (S	treet and Number	or Rural Route Number,
d in	5	4 Homicide	building, etc. (Sp	ecify)	, ,		City or Tow	n, State)	
completely filled in by the funeral director, page 2 should be deteched for use as Medical Certification. To Be Commisted by Obvetclan Medical Certification.		(Check only 2 Medical Examin	sician: To the best of my ner: On the basis of exar	knowledge, death	occurred at the tin	ne, date and place, pinion, death occur	and due to the c	ause(s) and manr late and place, an	ner as stated. d due to the cause(s)
Maple Maple		one) 29b. Signature and title of certifier	and manner stated.		29c. License				(Month, Day, Year)
- 8		Service of the line of continue			D36			0 23	
	-	' //						7/23/	v
6		30. Name and address of person who co				a 1 1111-	m	D 20	657
						9, LUSTE	57	DEV	63/
State Registrar		PAT A	32. Registrate S	.g. alui o	1 10				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OF AM IDNES Octiber 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kandallstown Hospital Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 1□ M 2 F Months Days Hours 241-38-1730 0-23-1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No BALTIMORE GWYNN UAKS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1401 21207 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) Ches/cook 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY JONES CORNELIA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEA H. BROWN 1901 HILLCREST ROAD GWYNN VAKS, NO 21207 NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/27/08 BUZZARO ROUT CEMETERY JACKSUMBURD, SC 21. Signature of Funeral Service Licensee BIANCHIFUN SORU 814 UPSHUR STAW WASHOR 20011 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cedemia Due to (or as a consequence of): Kenal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last De hy dration Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than mit it event, ITE Medical Examiner must be refilled at any injury or other traumatic event, ITE Medical Examiner must be refilled at

Baltimore, Maryland 21215-0036

burial-trar

and physician attending plant signed by the a has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, page

The law requires that the death certificate be executed

P.O. Box 68760

of Vital Records,

Division

Examine Physician/Medical Completed Be Medical Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☑No 9 Unknown

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 🗌 Suicide

4 Homicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 2 100

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifierlouin 29c. License number 65843

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) October, 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Randalls town, MD

State Registrar

6

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 1:25 HERMAN SONES 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie RINKE BOWIE HEALTH If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days 12 M 2 F Hours 419 32 0847 79 20 Director 1928 ALABAMA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show notified 1 X Yes 2 □ No Directo MD PRINCE GEORGE'S MITCHELLVILLE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9 20721 USA 1314 PEACHTREE COURT ural", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 NoARMY If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc within 72 hours after 1 Never Married 2 Married "natural", or BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify 3 XWidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) **PROFESSOR** PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill int of Health and Mental H: If Item 27 is marked oth ANNIE MAE ROGERS **JONES** OATHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 PEACHTREE COURT MITCHELLVILLE, MARYLAND 20721 CLIFFORD D. JONES/SON permit. Pages 1 ar Department of Hea Important: If Item; any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 10-24-08 CHELTENHAM, MARYLAND 21. Sign dure of Funeral Service Linensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) P.O. I Yes 2 No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should need 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? certificate 2 No 2 No Physiclan: uneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 ER/Outpatient 3□ DOA 1 🗀 Inpatient မှ After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation or Attending (Month, Day Year) Injun ospital c. 4 hours after deau.. -ral Director: Aft 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

B

ra

within 24 hours a To the Hospital

Medical

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** October 21, 1:50 P M JERRY D. JONES 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1**x** M 2□ F Hours Director 224-68-0025 62 6/9/1946 Clayton, NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the the death is an interest or the traumatic event; the the death of ponce. 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits ty⊡Yes 2 □ No Directo Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Numbe 3604 Fallstone Court 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify \$ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier <u>S. Postal Service</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Auther Jones Norall Jones ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Fallstone Court Fort Washington, MD 20744 <u>Sylvia C. Jones / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/08 4 Donation 5 Other (Specify) Maryland Veterans Cheltenham, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Onset and Death Immediate Cause (Final m **Physician** RNS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) □Yes 2□No the signed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ Ho 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I perforn 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 A Natural Year) 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certion who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day State OCT 2 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:51 AM George Melvin Jackson 2008 OCTOBER 22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Burnie ANNE Washington Medical Center Glew RAltimore 8. Date of Birth (Month, Day, Year) June 22,1930 If Under 1 Year If Under 24 Hrs. 6 Se 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days 1 X M 2 □ F 214-28-4474 78 Washington, Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d Inside City Limits 1 □Yes 2 No W Great Cacapon Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25422 USA P.O. Box 481 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1950—1952 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 K Married 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic Greyhound Bus 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Edward Jackson Ada Cecilia Dean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellouise L. Jackson / Wife P.O. Box 481, Great Cacapon, West Virginia 25422 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/29/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22, Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 RAY Rugas Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) IF FEMALE If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 2 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Matural 5 ☐ Pending investigation

Physician /Medical Examiner requires that the death certificate be executed and ing physician ar

Box 68760

P.O. E

Physician

/Medical

Examiner

Funeral

Director

show

items 23a

Director

Funeral

2

Completed

Be

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, "he Modical Experiment is ust be notined at

Baltimore, Maryland 21215-0036

2 should be fi

Health

permit. Pages 1 Department of It Important: If it any injury or o

> Examiner Physician/Medical the attending p signed by the a been

After this certificate has funeral director, page 2 s

ģ Completed Be P Certification:

of Vital Records, or Attending Physician: Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. To the

State Registrar

Medical

31. Date filed (Month, Day, Year) 2 8 2008

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

6 ☐ Could not be

determined

29c. License number

1 (4-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of persor

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

LEONARD M. JOHNSON
08-07940 Please Tun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNK UNK		1- For State Registrar	tate of Mary	-	partment of ertificate of		d Menta	Hygiene	Reg. No	. 20	08 3595	
Physicia Medical Examir	n/	Decedent's Name (First, Mid Leonard M		hnson				2. Date of Month Octob		Year	3. Time of Death 0551 hrs	
for tracky		4a. Facility Name (if not institute Prince Georges Hos		number)	-	tb. City, Town, or Cheverly	Location of D	1.0	- 4	4c. County of D Prince Geo		
Funeral Director		5. Social Security Number 579-84-8406	6. Sex	1 , ,	last birthday)	If Under 1 Year Months Days			,		Birthplace (State or oreign Country) D • C •	
any		Usual Residence of Decedent 10a. State 10b. Count			ty, Town or Locat						10d. Inside City Limits	
<u> </u>	ctor	D.C. 10e. Street and Number	·	W	ashingto	n 10f. Zip Code			100 C	itizen of What (1 X Yes 2 No	
ith the Maryland 23a or 28a-f show notified at once.	al Director	1313 Harvard				20010				U. S. A	١.	
after death winer, or items	by Funer		Married Armed 1 X Yes Divorced If Yes, Give Yor Dates:	^{′ear} 77 –	79 1 1	s Decedent of His es, specify Cuban Yes 2 X No	, Mexican, Pi	uerto Rican, etc	:.)	White, et	Black	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (S) Elementary/Secondary (0-1) 12th	2) College	rade completed) (1-4 or 5+)	during m	it's Usual Occupation of working life.	DO NOT us	e retired)		Civil S		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. funt: If item 27 is marked other than 'or other traumatic event, the Medical	Be	17. Father's Name (First, Midd Neshiel Joh	nson					lame (First, Mid Ly Lamp				
MD 21 nd 2 should I tith and Mer m 27 is man aumatic ev	5	19a. Informant's Name/Relatio Sally H. John		other)		Address (Stree	**	asiiii	igcoii, i	20001		
Baltimore, ME permit Pages I and 2 si Department of Health an Important: If item 27		20a. Method of Disposition 1 X Burial 2 Cremati 4 Donation 5 Other	on 3 Remova	from State	p. Place of Dispos crematory or ot antico	her place)		Date 10/31/		Triang!	ty or Town, State	
Balti permit. Departn Importi injury		21. Signature of Funeral Servi		. CC3	6/ 34	ame and Address W H B 47 14th	of Facility ACON F St., N	uneral I.W. Wa	Home,	Inc.	. C. 20010	
Physician /Medical xaminer		23a. Part I. Enter the disease, failure. List only one cause Immediate Cause (Final disease)	se on each line. se a. <u>Pho</u>	t caused the dea	ath. Óo not enter t	he mode of dying,	such as card	liac or respirato	ory arrest, s	shock, or heart	Approximate Interval Between Onset and Death	
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Vital hysician: this certi	o Be	25. Was case referred to medi examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	✓ ER/Outpatient		Other:	heck only one) Nursing Home	5 Resi	idence 6	Other:	
ion of Vending Ph. eath. or: After the funeral	ation: T		28a. Da (Mo ending vestigation	ate of Injury onth, Day,Year)	28b. Time of		ry at Work? Yes 2 N		cribe how i	injury occurred		
Division To the Hospital or Attentii within 24 hours after death. To the Funeral Director: A	Certification:	3 Suicide 6 Co			t home, farm, stre	et, factory, office t	ouilding, etc.		ation (Stree own, State)		or Rural Route Number, City	
o the Ho ithin 24 l o the Fir	Medical		Physician: To the I xaminer:On the bas and manne	is of examination								
F * F 8	Me	29b. Signature and title of cert		4		29c. Licens O.C.			29d. Date signed (Month, Day, Year) October 23, 2008			
CR 1		30. Name and address of pers Melissa Brassell, Mi		ause of death (It		Penn Street, E	Baltimore,	MD 21201				
St Regist	ate rar	31 Date filed (Month, Day Year NOV 0 5 2008	(r) (32.	Registrar's Sign	ure							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 0-00-2008 Physician 10;20a M Kathy V. Jerry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner P.G. Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 □X G.A. Director 578-74-2304 06-22-1953 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at P.G. District Heights 1XYes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20747 U.S.A. 6602 Atwood St. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black Specify: Black, hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 H Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) than Private Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Ith and Mental Hygie 27 is marked other I r traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) I and 2 should be fill lealth and Mental F Lois Cummings David R. Jerry Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau Mechelle Leak/Sister 3102 Viceroy Ave. District Heights, MD 20747 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Heritage Cemetery 10-20-08 Waldorf, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral HM 21. Anatur of Funeral Service Licenses 10583 Middleport Ln. White Plains, MD 2069 Konold Del 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Acute Ventricular Fibrillation Sequentially list conditions, if a.i.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of). Coronary Artery Disease certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Metastatic carcinoid tumor, Hematoma abdomen and 1X Yes 2 No 3 Probably 4 Unknown Completed Pelvic region, Chronic Atrial fibrillation, END 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 X Yes 2□ No stage renal disease, Diabetes mellitus non insulin dependent ves 2010 Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 XNatural Injury 5 Pending or Attendir fter death. Director At 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier, 29c. License numbe 29d. Date signed (Month, Day, Year) October 21,2008 D24720

State Registrar 31. Date filed (Month, Day, Year) OCT 2 3 2008

Ravinder K. Rustagi, M.D. - 6132 Landover Rd., Cheverly, Md. 20785 32. Registrar's Signature

tweeless 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-07807 Jean Kearney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b-State of Maryland/ Department of Health and Mental Hygiene 2008 35957

		- For State Registrar				Certi	ficate of	Deat	h			R	eg. No.	_		
Physiciai ledical Examin	1 /	7 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Ye										Year		ne of Death 335 hrs		
iculcal Examin		JEAN 4a. Facility Name (if not institution	on, give s	treet and no	umber)	KI	EARNEY 41	o. City,	Town, or Lo	ocation of		October		ounty of D		
		E/B Suitland Pkwy we	est of S	Suitland F	Rd			Suitla	and	1		F195		ice Geo		j.e
Funeral		5. Social Security Number	6. Sex		7. Age (Ir	yrs. last	birthday)	If Und	er 1 Year	If Under :	_		,			(State or Foreign
Director		578-80-5844	1 N	2 X F	50)	Yrs.	Mona	10 20,0	110010		MARCH	22 19	158	WASHI	INGTON, DC
á .	- 1-	Usual Residence of Decedent 10a. State 10b. County				c. City, To	own or Location	n							10d.	Inside City Limits
Maryland 28a-f show any d at once.	ٰ	MD Princ	s Ge	eorge'	s	B	A LTIMOI	Æ	Fores	tvil	1e				1 🛚	Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 5839	Hi1	Mar	Driv	2		10f. Zip	Code	207	4.7	T 1	I0g. Citizen	of What (Country?	
h the Na or otified		111 PENN STRE	ET						201					JSA		
th wit lems 2	Funeral	11. Marital Status 1 Never Married 2 N	arried	12. Was De Armed F	orces?				ent of Hispa ify Cuban, N			ify Yes or No can, etc.)	o- 14.	Race - A White, et		dian, Black,
ter dez			7	1 Yes Yes, Give Ye	2 X ar	No	1	Yes 2	X No	specify:			Sp	Specify: BLACK		
ours af	g-	15. Decedent's Education (Sp		or Dates:		ted) 1	6a. Decedent	s Usual		n (Give kir			16b. Kind	of Busine	ess/Industr	
2036 within 72 hou iene. rer than "nat	ompleted	Elementary/Secondary (0-12		College (1-4 or 5+)				-			1)			(T) I	.1
within giene.	틹	12th 17. Father's Name (First, Middle	Lact)				BUILI	DING	ENGI			irst, Middle,		VERNM	1ENT	
21215-0036 ald be filed within 7. Mental Hygiene marked other than event, the Medical	Be	NATHANIEL E.		TAMS								RAWFO		,		
		2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To														
MD 1d 2 sho alth and m 27 is	1	SHARRON L. WILLIAMS/DAUGHTER 3717 DONNELL DRIVE FORESTVILLE, MAR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location														
Baltimore, permit Pages I ar Department of Hee Important: If ite Imjury or other tr		1 X Burial 2 Cremation 3 Removal from State crematory or other place)										•				
Itim it Pag riment orfant:	-	4 Donation 5 Other Specify: HARMONY CEMETERY 10-24-08 LANDOV 21 Signature of Funeral Stayle I censee 22 Name and Address of Facility J. B. JENKINS FU														
Baa Perm Depa Impe	d	Signature of the latest	2001130									LAND				
Physician	7	23a. Part I. Enter the disease, of failure. List only one cause	r complic	ations that	caused the	death. D									App	proximate Interval
/Medical xaminer	1	Immediate Cause (Final diseas	a. N	lultiple In												Death
	-	or condition resulting in death)	Di b	ue to (or as	a consequ	ence of):										
	를	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.		ue to (or as	a consequ	ence of):										
	티	(Disease or injury that initiated events resulting in death) Last	6:	ue to (or as	a consequ	ence of):		-							-	
6 be executed ysician and burial - transit			d													
760, cate be execut physician and he burial - tra	n/Medical	UNPENDED		AMENDED												
8760, tificate be ng physic as the bun	Š	IF FEMALE: 23b. Was decedent pregnant in	he	23c. If yes, 1 Live		of pregna		al death	3	Ectopic	pregnanc	у		Date of de onth	livery Day	Year
Box 68 he death certi	Physicia	past 12 months?	known		nant at tim	e of deat	h	ier (Spi	ecify)							
the dea	ڇَ	Part II. Other significant cond		9 Unkr		ıt not res	ulting in the u	nderlvin	o cause oiv	en in Parl	t I.	23e. Did	tobacco use	e contribu	te to the ca	ause of death?
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Vital Rec ysician: The his certificate director, page	ပေါ	25. Was case referred to medic							26.Place o		Check on			L		
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Division tal or Attendir rs after death. al Director: A	Oct 16, 2008 1327 hrs Investigation Oct 16, 2008 28e Place of Injury - At home farm, street factory, office building, etc. 28f Location (Street and Number or Bural Re															
DIVI Spital or , sours after neral Dire	E		ild not be ermined) Major	Road	/ Highway				E	or Town, /B Suitland	State) Pkwy we:	st of Suit	land Rd,	Suitland, MD
8 - 8	Sal	29a. Certifier 1 Certifying I	hysicia	n: To the be	est of my ki	nowledge	e, death occur	ed at th	ie time, date	e and plac	ce, and d	ue to the car	use(s) and r	manner as	stated.	en(e)
To th within To th	Medical	one) 2 Medical Ex	í	and manner	stated.	ation and			c. License		urreu at i	ine time, dat			(Month, D	
	-	29b. Signature and title of certif	00/	a n	0				O.C.M					er 17, 2		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(10)	-	30. Name and address of person	n who co	mpleted car	use of deal	h (Item 2	(3a)							,		
es e				t Medica			11 Penn S	Street,	Baltimo	re, MD	21201					
Sta	ite	31. Date filed (Month, Day Year OCT 2 2 2008	6.	32. F	Registrar's	Signature	1									
Registi	CLI	00122200	_ /26	1	W.	444										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician OCTOBER 10 2008 6:30 P M MARIATU MUSA KARGBO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BOYDS 14217 ASHLEIGH GREENE ROAD If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 M 2X F 9 1965 SIERRA LEONE Director JÙLY 43 215-47-0958 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examirer must be retified at BOYDS 1 Yes 2 □ No MD MONTGOMERY Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Decrnit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Importavt: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, Ire Medical Examirer must once. 20841 SIERRA LEONE Funeral 14217 ASHLEIGH GREENE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XNo BLACK Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE NURSING ASSISTANT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTHA SESAY TURAY ည SAIDU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14217 ASHLEIGH GREENE ROAD BOYDS, MARYLAND 20841 AYESHATA SINLAH/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State FREETOWN, SIERRA LEONE 10-24-08 Donation 5 Other (Specify) FAMILY PLOT uneral Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC RENAL CARCINOMA SPINE AND PARASPINAL /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 No 1 ☐ Yes Attending Physician: After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation spital or Attendi lours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospita within 24 hours a completel. ... 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 15, 2008 D0055522 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 ROBERT H. GERARD M.D. 31. Date filed (Month, 32. Registrar's S 2008

DHMH 17 Rev 1/2001

State

Registrar

OCT 1 6

		,	1 - State of Maryland / E	Department of F Certificate of		, ,	ene , No. 2008	35959
ı	Physici	an	Decedent's Name (First, Middle, Last) Georges W. Kelly			2. Date of Death Month	Day Year	3. Time of Death 5 15 AM
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death		20 / 2008 4c. County of Dea	
- Park			Sligo Creek Nursing & Rehab	Takoma			Montgom	
	Funeral Director		37, 10 313,	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		rthplace (State or Foreign Country)
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town					10d. Inside City Limits
	Ra-fst	Director		ashington	_			1—Yes 2□No
	3a or 3	al Dir	10e. Street and Number 1116 46th Street SE	10f. Zip Code	0019	10g	U.S.A.	ountry?
036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examples to the filed.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
15-003	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of work	king 16	b. Kind of Business	s/Industry
2121	d within giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		nker		Governm	ent
Maryland	e d tal	To Be C	17. Father's Name (First, Middle, Last) Henry Kelly		18. Mother's Nam Hannal	ne (First, Middle, Ma Lavar	,	
lary	S S S	-		Mailing Address (Street	and Number or Ru	ral Route Number, C	City or Town, State,	Zip Code)
	ss 1 and 2 of Health Item 27	8		04 Greenlei Disposition (Name of			rginia c. Location - City o	
altimore,	S = = 0		cemeter	y, crematory or other place ncoln Cemet	:e) !		•	Maryland
Balt	permit. Page Department of Important: If any Injury or once.	ļ J	21. Signature of Funeral Service Licensee	22. Name and Addre 3401 Blade				
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrivation and Due to (or as a consequence of the control of the	hymia				Instant
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	f):				
o,	ficate be executed physician and s the burial-transit	I Exa	resulting in death) Last Due to (or as a consequence or	f):				
68760,	ificate l g physic s the b	edical	d					
C. Box	that the death certific ed by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year
S, F	w requires that the d s been signed by the should be detached	ğ	Part II. Other significant conditions contributing to death but not resulting in Sepsis	the underlying cause give	en in Part I.			to the cause of death?
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a Ke	sician: The law certificate has t irector, page 2 s	Completed	H T N			autopsy performe 1 ∐Yes 2 ½	d? prior to	completion of cause of
Z	siciar certif irector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	nationt 3 🗆 DOA Oth		th (Check only one)		
n or	ilng Phy After this 'uneral di	ion: To	27. Manner of Death 1 Natural 5 Pending 1 Inpatient 2 EP/Out 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending	ime of jury 28c. Injur	y at (?	ome 5 Residence 28d. Describe how		ecify)
UNISION	or Attenction for the firector:	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, far		Yes 2□No	28f. Location (Stree City or Town, S		Tural Route Number,
ב	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.		29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, (Check only 9) Medical Examiner: On the basis of examination and	death occurred at the tir	me, date and place	, and due to the cau	se(s) and manner a	as stated.
_	ithin 24 the F the F	Medical	(Check only 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	29c. License			and place, and du	
)	F > F 8		bash =	D28			ober 24	
	Ó		30. Name and address of person who completed cause of death (Item 23a) (-
	Sta	e.	Ravi Passi MD 15225 Shady Gro	_	8 Rockv	ille,MD	20850	
	Registr		OCT 2 4 2008	parte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			forAmend Item 16a State Registrar16b WCHD/SH	1, State of Ma 1 10/30/08	per FG <i>Ce</i>	ariment of r rtificate of	neaith and i Death		ene _{g. No.} 2008	35960
	Dhyaisi		1. Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Helen Amelia Lo	gan					26, 2008	10:10 A M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th
4			Ravenwood Assiste			Hagersto			Washingt	
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		214-09-62/2)3 ^{ris.}		<u> </u>	August 3	1,1915 Mar	yland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	//anyl	5								1 ∐Yes 2 No
	the 1	Director	Maryland Washingt 10e. Street and Number	on	Hagersto	10f. Zip Code		10	og. Citizen of What Co	ountry?
	with with		1109 Luther Dr.			21740				,
	ms 2	Funeral	11. Marital Status	12. Was Decedent B	ver in U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	U.S.A.	erican Indian,
9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XN If Yes, Give	lo			Rican, etc.)	Black, White	e, etc.
03	ral", c	ğ	3 Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Evolution of until be medified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	oation	ina 1	6b. Kind of Business/	Industry
7	ithin ne.	ď	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	during most of work d) Caferer	ffa B	oard of Ed	lucation
7	ygien ygien ner th	S		4	P	coduction	Worker			<u>Manufacturin</u>
밀	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname)	
Maryland	should and Mer s marke umatic	ဥ	Harry Morgan				Annie	Spicer		
Jai	2 sh n and rs m	10	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State, 2	Zip Code)
	iges 1 and 2 should be filed within 72 hours after death with the Marylar in of Health and Mental Hygiene. If file at 21 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Medical Exemitive", and by rediffed at		Linda Elliott /	<u>Daughter</u>	3538	Glen Abb	<u>ey Dr. Ch</u>		rg, PA 172	
altimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	osition (Name of matory or other plac	ce)	Date 2	0c. Location - City or	Town, State
Ē.	t. Pa trant: tant:		4 □ Donation 5 □ Other (Specific			en Cemete	ry 10/30	/2008 H	agerstown,	Maryland
Ba	permit. Pages 1 al Department of Hes Important: If item any Injury or othe once.		21. Six at a of Funeral Service Licer	se/)					Funeral Ch	
	40 = 8 G	-	man.	'd~~						ryland 21742
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that c <i>a</i> used one cause on each lin	the death. Do not en e.	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
- F	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Cari	inome c	ilan				3 m
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):					
		<u></u>	Sequentially list conditions,	b. Due to /or on	a consequence of):					
	ted isit	nin l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events	Due to (or as a	consequence or).					
	al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
68760,	tricate be executed g physician and as the burial-transit	ia E								
687	Tificate ig phy as the	ledical		, a						
Вох	eath cert attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of del	ivery
m į	deatr	icia	In the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	ey .		Month	Day Year
0	requires mat me death cer seen signed by the attendir nould be detached for use	Physician/N	9 Unknown	9 ☐ Unknown						
·,	s ma med l	by P	Part ii. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	quires an sign	<u>8</u>	Anterio Schere	The Canal	io varace	Dire		1 ☐ Yes	s 2 □ No 3 □ Pr	obably 4 Onknown
Records,	aw Is t	olet	respecterion	chraic	kilm	sincen		24a. Was an		topsy findings available
	ine iaw ate has b oage 2 sh	Completed						autopsy	ed? / death?	completion of cause of
		Be C	25. Was case referred to medical				26. Place of Deat	1 □Yes 2		2 No
	rnysician: this certific ral director,		examiner? 1 ☐ Yes 2 ☐ Mo	Hospital:	nt 2 ER/Outpatie	nt 3 DOA Oth			nce 6 Other (Spe	EL CALLET A
	utending Physical death. ctor: After this if the funeral directions of the funeral directions of the funeral directions.	Certification: To	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injur Wor		28d. Describe hov		
0	Attending r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		, reary		Yes 2 □ No			
Division	2 6 6	ti li	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Stre	eet and Number or Ru	ıral Route Number,
<u> </u>	rs aft al Di	Çe		3			50			
	e nospital or Attendi 124 hours after death. e Funeral Director: A letely filled in by the fo	cal	(Check only 2 ☐ Medical Exan	ysician: To the best on the basis of	examination and/or in	h occurred at the till exestigation, in my o	me, date and place,	and due to the ca	use(s) and manner as	s stated. to the cause(s)
4	vithin 24 hours after or vithin 24 hours after To the Funeral Discompletely filled in	Medical	one)	and manner sta	ted.					` '
F	5 ¥ 6 0		29b. Signature and title of certifier	MO		29c. Licens		29	d. Date signed (Monti	i, Day, Year)
							18019	/	0/21/0	8
41.1	- 2		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	. /	C 11/2-		7	
יוק	Sta	to.	V ASAUT DAT	32. Raistra	r's Signature	1. 1146	EISTOW	OWP	21740	
	Sta Registra			008	M A	months!				
	H 17 Day 1/0/			The state of the s	The same of					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Veal Month Day ctober Tomasino Gloria LaFay 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death Sivai HOS Balt TUIO JE baltimose tal If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Connecticut 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days 1 □ M 2 🕱 F 82 June 18, 1926 042-22-2614 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Virginia Fairfax Falls Church 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 6523 Crosswoods Drive 22044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Writer/Researcher Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Tomasino Lena Valente 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Connolly (Daughter) 6878 LaFayette Park Drive, Annandale, VA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 12/3/08 Arlington, VA 22. Name and Address of Facility Murphy Falls Church Funeral Home ignature of Funeral Service Licenses 1102 West Broad St, Falls Church, VA 22046 1 ann eal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) REVIMOUIA Due to (or as a consequence of): peritoneal shout intection Ulo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last droce olla Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

P.O. Box 68760,

The law requires that the death certificate be executed burial-transit physician the use as attending p ned by the a signed by Division of Vital Records, pe this certificate has been page 2 ital or Attending Physician: director, After urs after death. eral Director: Af illed in by the fur

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. M. Alfahl Evering the notified at anone.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

by Funeral

Completed

Be

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Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

	10),
To the Hosp within 24 hou	To the Fune completely fi	

31. Date filed (Month, Day, Year)
OCT 2 2 2008 tate Registrar

29b. Signature and title of pertifie

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

pleted cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signat

28a. Date of Injury (Month, Day, Year)

and manner stated

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LESTER DEIDRE OCTOBER 2008 12 7:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗓 F Hours Min. 212-84-8580 Director 44 1963 WASHINGTON, DC 6 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Director 1 X Yes 2 ☐ No MD PRINCE GEORGE'S LAUREL 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9010 BRIAR CROFT LANE # 218 20708 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Completed by Yes, Give BLACK 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) yrs ACCOUNTANT PRIVATE of Health and Mental Hygi Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be WALTER LEE PITTS GRACE ELIZABETH MOSES မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE ELIZABETH MOSES/MOTHER 9010 BRIAR CROFT LANE # 218 LAUREL, MARYLAND 20708 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If Ite any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 10-17-08 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND -D-1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner una me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Malishant
Due to (or as teonsequence of): burial-tran the attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 □Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 ☑No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes \$ No Japatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 13/0 FARZAD MALEKANIAN M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suxxa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 15 2008 13:05 M **Physician** THELMIAH LEE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY P.G. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APRIL 12 9. Birthplace (State or Foreign Occupatry)

9. N. C. 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours Min 1929 1 🖳 M 2 🗆 F 79 242 42 4017 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at CHEVERLY ty⊡Yes 2 No Director MD. P.G. 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number filed within 72 hours after death with 20785 USA 2900 MERCY LANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ∏Yes 2 TXNo Specify. þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SALESMAN and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be 1 THOMAS LEE CORA MACON SAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 14 ROANOKE RAPIDS, N.C. SHERMAN W. LEE/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or ott Burial 2 Cremation 3 Removal from State 10/21/08 LANDOVER MD: HARMONY MEM. PARK 4 Donation 5 □ Other (Specify) 20010 22. Name and Address of Facility 21. Signature of Funeral Service Licenses WATSON F. H. 3435 14th ST. N.W. WASH DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final minutes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner tre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tran Due to (or as a consequence of) Box 68760, physician pe INDMO Physician/Medical the 88 IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ♣ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à End stage scual reardial mearction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed tel melleters 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No death. filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

o. ۵. Division of Vital Records, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

20

Registrar

6132 31. Date filed (Month, Day, Year) OCT 2:0 2008

29b. Signature and title of certifier

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVINDER K. RUS

6/3 2 LANDOVER ROAD, CHEVERLY, MD

and manner stated.

29c. License number

D24720

29d. Date signed (Month, Day, Year)

15/08

			For	State of Marylan	_			Mental Hyg	jiene			
		_	State Registrar		Cei	rtificate of I	Death		eg. No. 2	08	35964	
	Physici /Medic		Decedent's Name (First, Middle, La HARRY M	·	DERS			2. Date of Dea Month OCTOBER	Dav	Year 08	3. Time of Death 7:47 P M	
	Examir		4a. Facility Name (If not institution, giv	· ·		4b. City, Town, or		h	4c. County of			
			PRINCE GEORGE		for met frinelle elevel	CHEVER If Under 1 Year	LY If Under 24 Hrs.	O Data of Dist	PRINC			
L	Funeral Director			Sex 1 □XM 2 □ F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day MARCH 1	0 1909	9. Birthpl Count WASI	ace (State or Foreign INGTON, DC	
	land ow at		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				11	Od. Inside City Limits	
	Mary a-f sh ified	ţċ	MD PRINCE	GEORGE'S	CHEVER	LY					1 XYes 2 No	
	or 284 e not	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	try?	
	ath wi	la	2806 CHEVERLY AV			2078			USA			
980	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐XYes 2☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 21 No	ispanic Origin? (S an, Mexican, Puer Specify:	specity Yes or No- to Rican, etc.)		- America k, White, e		
5-0	72 hc 'natur	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	dent's Usual Occup	ation during most of wo	rkina I	16b. Kind of Bus	siness/Ind	ustry	
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		kind of work done of DO NOT use retired SICIST	i)	, Aling	GOVER	NMEN'I	2	
Maryland		To Be (17. Father's Name (First, Middle, Last HARRY M. LANDER	,			18. Mother's Nar	ne (First, Middle, Maiden Surname) SCOTT				
lary	and s m		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numbe	r, City or Town, S	State, Zip	Code)	
	an n 2			S/WIFE		CHEVERLY						
Baltimore,	a to to		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State 20b. F	Place of Dispo semetery, crer	sition (Name of matory or other plac	ce)	Date	20c. Location - (City or To	wn, State	
tim			4 □ Donation 5 □ Other (Special		IARMONY	CEME 2. Name and Addres	TERY 10-	-27-08	LANDOVER	MARYI	AND	
Ba	permit. Departr Importa any inji		21. Signature of Functal Sentice Life	nsee 7	J. B. JE	NKINS F	UNERA	AL HOME				
	37/13		23a. Part1. Enter the disease, or corr shock, or heart failure. List only	pplications that caused the deat	AD LANDOV		LAND	Approximate				
	Physician	0.9	Immediate Cause (Final	one cause on each line.						- 1	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq	uence of):	ARDIAC	11146	17771	1			
84	Examiner	١. ا	Sequentially list conditions,	b								
-	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Dualto (or as a conseq	uence of y					="		
-	xecut and al-tran	хап	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):	·						
68760,	ficate be executed physician and s the burial-transit	<u> </u>	· ·	, d								
		edical		d								
P.O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ldeath 3□	Ectopic pregnancy Other (specify)	/		23d. Date Mon	e of delive nth	ry Day Year	
	uires that n signed t	þ	Part II. Other significant conditions COLON CAN		ulting in the u	nderlying cause give	en in Part I.	23e. Did to			e cause of death?	
000	law requii as been s 2 should	olete	PERNICIOUS	ANFMIA				24a. Was a	ın 24b. W	Vere autor	osy findings available	
or Vital Records,	The ate has page	Completed						autop: perfor 1 Yes	med? d	eath?	npletion of cause of 2□ No	
Zi:	Physiclan: r this certificaral director, I	Be	25. Was case referred to medical examiner?	Hospital:		t 3DDOA Oth	or.	ath Check only or				
o	Phys er this eral di	년 -	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of	I SUI DOA	4 □ Nursing F	lome 5 ☐ Resid	ence 6 Dothe		")	
ion	nding F th. r: After e funera	ţi	1 Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year)	Injury	Worl	k?¨` Yes 2∐No	200. 200.120 11	on injury docume	, ,		
Division	al or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rurai	Route Number,	
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Pl	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place	e, and due to the curred at the time, o	ause(s) and mar date and place, a	ner as st	ated. the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	2/1/001	1	29c. Licens			29d. Date signed	(Month, I	Day, Year)	
		1	The	KKK	12	ND	13026		10/17	108	7	
	10		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,			/	-1	100		
			STEPHEN SEABRON				PARK, MA	RYLAND 2	0913			
a al	Sta Registi	_	31. Date filed (Month, Day, Year) OCT 2 4 2008	32. Registrart Signa	grade	,						

08-07748 Wayne A. Lipford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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9	partment	of Health	and	Mental	Hygiene	

2008 35965

	1- For State Certificate of Death Reg. No.													
Physicia dical Exami	an/	 Decedent's Name (First, Middle,L 	Decedent's Name (First, Middle,Last) Wayne Alan Lipford 2. Date of Death Month Day October 14, 2008								008		Time of Death	
		4a. Facility Name (if not institution, g Prince Georges Hospital			41	Cheverly		ation of D				c. County of Prince Ge	orge's	
Funeral Director			Sex 7. Age	e (In yrs. last bird	thday) Yrs.	If Under 1 Months	$\overline{}$	f Under 2 Hours	Min			1965	9. Birthpla Foreign W Country	ashington,DC
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.	ted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 3627 Pocono Pla 11. Marital Status 1 X Never Married 2 Marr 3 Widowed 4 Divor 15. Decedent's Education (Specific Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L. William Alan Li 19a. Informant's Name/Relationshil William Alan Li 20a. Method of Disposition	If Ye 1	10f. Zip Co 20 s Decedent ces, specify C Yes 2 X Ys Usual Occost of working e Clim p Address (Poconcition (Name	705 f Hisparuban, Mo No signification upation g life. DO ber 18.1 FStreet all	Mother's Kath nd Numb ace,	nd of works retired Name (F 1een per or Ru Be1	rk done d) First, Middl Ann iral Route I Ltsvil Date	No- 16b S e, Maide New Number, 120	White, Specify: Kind of Bus elf Emen Surname) mam City or Town MD 20 c. Location -	American etc. Whit iness/indu ploye , State, Zi 705	e d p Code)		
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	Je 4/100 the live that squared the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									alti vill	more Ave.			
' edical ≀aminer	aminer	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate once. Enter the death of Coisease or injury that initiated events resulting in death) Last	a. Multiple Gunsh Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons	sequence of):										Death
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Yo the Funeral Director: After this certificate has been signed by the attending physician and comminant of the high signed and a standing the former of the comminance of the former of the comminance of the standing physician and the original properties of the standing physician and some former of the former of the standing physician and some former of the standing physician and some former of the standing physician and standing physician physician and standing physician and standing physician and standing physician physician and standing physician physician physician and standing physician physi	sician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	nown 9 Unknown	at time of death	2 Fe	etal death ther (Specif)					23d. Date of Month	Day	Year e cause of death?
of Vital Records, P.O. ng Physician: The law requires that the there this certificate has been signed by Incord director, mane 2 should be detacht	Complete	Part II. Other significant conditions and the significant conditions are significant conditions.		th but not result	ting in the		.Place c	of Death (1 24a. V		2 ✓ No 3	Proba	psy findings available impletion of cause of
/ital ysician: his certifi		examiner?		tient 2 🗸 ER	/Outpatien	nt 3 DO	A O	other 4		g Home 5		sidence 6	Other:	
on of \text{lending Physicath.} or: After the funeral	tion: To	27. Manner of Death 1 Natural 5 Pend			b. Time of 337 hrs	.,.,		at Work	. 19	Subject	shot	/ injury occurr		
Division pital or Attendi ours after death. eral Director:	<u>ાં</u>	3 Suicide 6 Could	d not be	Injury - At home			office bu	ilding, et	c.	28f, Locat or To 5211 Flin	ion (Stre vn, Stat tridge [et and Numb e) Drive, Lando	er or Rura ver Hills	I Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical Co	29a. Certifier	hysician: To the best of miner: On the basis of ex	camination and/c	death occu or investiga	urred at the t ation, in my	me, date	e and pla death oc	ace, and curred a	due to the t the time,	cause(s date and	s) and manne d place, and o	r as stated due to the	f. cause(s)
To with	Med		and manner state	u		29c.		number			2	9d. Date sign October 1	ed (Mont	
y	Œ.	30. Name and address of person Patricia Aronica-Pollal		f death (Item 23 Medical Exa	a) aminer	111 Pe	nn Str	eet, Ba	altimor	e, MD 2	1201			
	State	5 5 5 10 d 6 V	32. Regist	trar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 1047AM 08 0 26 Liston, Sr /Medical Kenneth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sq15b// Year If Under 24 Hrs. Hospice Lake 9. Birthplace (Country) the -oastal If Under 1 Year (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Yrs. Director 183-16-0661 7-3-1916 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 2 should be filed within 72 hours after death with the Marylan nand Mental hygiene is and Mental hygiene. Its marked other than "natural", or items 23a or 28a-f show raumatic event, its affodical Examilier must be notified at 1 ☐ Yes 2X No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1109 S. Schumaker Drive USA Funeral 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Kenneth hstan Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White \$ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Optometrist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heaith and Menta Important: If item 27 Is marked any Injury or other traumatic ev ည Arthur Liston, Sr. Mary Kirhy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gizzi - Daughter 5895 Dundee Drive, Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Entombment Wicomico Memorial Pk. 10-30-2008 Salibury, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home YOU 705 E. Main Street, Salisbury, Maryland 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORONARY ARTER /Medical Due to (or as a consequence of): Examiner CARRER Sequentiany flet our diture, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. ned by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □ Yes 2 □ 196 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No **E** □ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

wary

COASTAL HOSPICA 32. gistrar's Signature

29c. License number

00058410

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 04:45 AM **Physician** 2008 HEON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 928 WICOMICO)elmar lournamen If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 1/17/1983 Birthplace (State or Foreign Country) Social Security Number 6 Sex Age (In yrs. last birthday) **Funeral** Months Days 219-55-3826 1**⋉** M 2□ F South Korea 25 **Director** Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland montal Hygiene. 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show ampligury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Maryland Wicomico Delmar Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21875 Korean 9281 Tournament Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Korean þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chef trainee restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chang Won Lee Jung Hwa Kim 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9281 Tournament Dr., Delmar, MD 21875 19a. Informant's Name/Relationship (Type. Print)
Chang W. Lee/father Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/29/08 Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22Holloways Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 David H. (hompson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to for as a consequency of: Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 212/No has page 2 certificate 1∐ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After 1 Natural Iniury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) att 604 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

			For	State	of Marylan		artment of H		Mental Hy	giene	
	3		1 - State Registrar			Ce	rtificate of L	Death		Reg. No.	35968
	Physici	an	Decedent's Name (First, Midd.						2. Date of De Month	aath Day Ye	3. Time of Death
V.	/Medi		Eugene Jose 4a. Facility Name (If not institution			•	4b. City, Town, or	Logation of De		22, 2008	8:06 p ^M
	Examir	ıer	Calvert Mem							4c. County of D	
1	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Prince If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th 9	Vert Birthplace (State or Foreign
	Director		229-36-0761	1 ∑ M 2□F	76	Yrs.	Months Days	Hours Mi	in. (Month, Da 2/27/	ıy, Year)	Country) [ew York]
	p ,		Usual Residence of Decedent		140.00	-				1932 11	
	anyla shov	2	10a. State 10b. County		10c. Cit	y, Town or Lo					10d. Inside City Limits
	the N	Director	MD Ca	lvert			Dunkirk				1X Yes 2 □ No
	with a or	ā					10f. Zip Code			10g. Citizen of What	Country?
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9	72 hours after death with the Maryland nature!, or Iteme 23a or 28a-f show dice Examinar must be notified at	Ē	1 ☐ Never Married 2 🔀 Mar	ned 1 ☐ Yes	orces? 2 📉 No		If Yes, specify Cubai	n, Mexican, Pu	erto Rican, etc.)	Black, W	
8	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or E	ve lates:		1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
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	iled v tygie ther t		17. Father's Name (First, Middle,	(1001)		Comp	outer Sa			Comput	er
and	d be f intal h ed of	Be								Maiden Sumame)	
Maryland	should nd Me mark matic	ြ	Silvio Eugen 19a. Informant's Name/Relations		LO	19h Mailir	on Address /Street a		Polgano	er, City or Town, Stat.	a Tie Codel
\mathbf{z}	nd 2 g		Joan Matullo							, MD 207	
ē,	s 1 ar f Hea item othe		20a. Method of Disposition		20b. P	face of Dispo	sition (Name of		Date	20c. Location - City	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-f show with fujury or other treumstic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service				. Name and Addres			-Wood F.H	
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é	47		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that o	aused the death	n. Do not ent	er the mode of dying	, such as card	ac or respiratory ai	rrest,	Approximate Interval Between
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8760,	icate be executed physician and s the burial-transit	a E			(0.000	30.100 31).					
687		edical		d.							
Вох	The law requires that the death certific tle has been signed by the attending p age 2 should be detached for use as	N	IF FEMALE; 23b. Was decedent pregnant		come of pregna					23d. Date of	delivery
	death e atte d for	Physician/M	in the past 12 months?	4□Pregr	ointh 2 Tetal nant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
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<u>≥</u>	after after Dire	Certification:	4 Homicide determ	buildi	ng, etc. (Specify	ne, ram, stre	eet, lactory, office		City or Tow	Street and Number or vn, State)	Rural Route Number,
	Hospital 14 hours a Funeral I		29a. Certifier 1 Certifyin	g Physician: To the	best of my know	wledge death	occurred at the time	a date and niad	ce and due to the	cause(s) and manner	as stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edicai	one) Z Medical	examiner: On the b	asis of examination stated.	ion and/or inv	estigation, in my opi	nion, death occ	curred at the time, o	date and place, and d	ue to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		7,,		29c. License	number		29d. Date signed (Mo	nth, Day, Year)
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	Sta Registra		31. Date liled (Month, Day, Year)	2 7 2008	egistra Signat	ure	Sparte				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 25, 2008 **Physician** 8:25 р м CHARLES HARRISON MEGEE, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO PITTSVILLE 8151 GUMBORO ROAD 8. Date of Birth (Month, Day, Year) 7-1-1942 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 152-32-0555 1 X M 2 □ F DELAWARE 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event. MARYLAND WICOMICO PITTSVILLE 1 ☐ Yes 2 No Director the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21850 8151 GUMBORO ROAD UNITED STATES Funeral 2 should be filed within 72 hours after death in and Mental Hygiene.

is marked other than "natural", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status rmed Forces? XYes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 59-61 1 ☐ Yes 2 🛛 No Specify \$ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED TRUCK DRIVER TRANSPORTATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MADELYN ELIZABETH SAVAGE CHARLES HARRISON MEGEE, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 148, PITTSVILLE, MD. 21850 PATTIE A. TINGLE/ COMPANION Health item 27 i Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 ment of H 20a. Method of Disposition CAPE HENLOPEN
CREMATORY Department of Important: If its any Injury or o 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 10-27-2008 FRANKFORD, DELAWARE 4 ☐ Donation 5 Other (Specify) 21. Signature Fundal 'ATT'SERVICES LTD STREET, FRANKFORD, DELAWARE. 19945 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate any leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No Ö 9 Unknown <u>~</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown should 1 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 □ Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Limited Carlot (as a cause (s) and manner as stated). Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu H54827 OCTOBER 28, 2008 3 Name and address if per on who complete cause of death (Item 23a) (Type, Print) RA 12+1 DR. MITCHELL GITTELMAN, 31413 WINTER PLACE PARKWAY, SALISBURY, MD. 21804

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2 8 2008

ORIGINAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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Funeral Director	. ~.	5. Social Security Number n/a		.6	_	Months Da				1 1002 CC	puntry)
any.		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Towr	or Location				•		10d. Inside City Limits
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e Maryl	Director	10e. Street and Number 322 South Lat	ne Ant B		10	Of. Zip Code 216	01		10	g. Citizen of What Cou Gautemala	intry?
with th		11. Marital Status	12. Was Deceden	t Ever in U.S.		ecedent of H	ispanic Origi	in? (Specify		14. Race - Ame	rican Indian, Black,
D 21215-0036 shours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Funeral		Married Armed Forces 1 Yes 2 ivorced If Yes, Give Year	? . X No		·		Puerto Ricar Guaten		White, etc.	
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2 S S S		19a. Informant's Name/Relation		100	-	,				ber, City or Town, Stat	e, Zip Code)
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imore, MD 2 Peges I and 2 shoul ment of Health and N fant: If item 27 is n or other traumatic		1 X Burial 2 Crematic	on 3 Removal from S	lale	atory or other atema1a		,	n/a		Guatemal	a .
Baltimore, MC pemit, Pages I and 2 sl Department of Health ar Important: If item 27	1940	4 Donation 5 Other 21. Signature of Funeral Service		1 545	22. Nam	e and Addre	ss of Facility	/			
		let C	m	/						neral Home 0 21639	
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one caus	e on each line.		not enter the r	mode of dying	g, such as ca	ardiac or resp	oratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final diseas or condition resulting in death)	a. Gunshot Wour			_	_	-	_		1
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n of Vital Rec Ling Physician: The After this certificate funeral director, page	ို	1 Yes 2 No 27. Manner of Death	28a. Date of In	ient 2 🗸 ER/	Outpatient 3 . Time of Inju		jury at Work	Nursing Ho		Residence 6 Oth	er:
on c ending ath. or: Aft	tion	1 Natural 5 Pe	nding Oct 24, 2008	Year) 220	04 hrs		Yes 2	. İSub	ject shot		
Division of Vital Be Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifetely filled in by the funeral director.	Certification:	3 Suicide 6 Co	uld not be	njury - At home,	farm, street, f	factory, office	building, et	c. 28f.	Location (S		Rural Route Number, City
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the the	Medical	(Check only Certifying	Physician: To the best of r aminer: On the basis of ex and manner stated	amination and/or	eath occurred investigation	d at the time, i, in my opinio	date and pla on, death oc	ace, and due curred at the	to the cause time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)
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			For		State of	Maryland	I / Dep	artment of H	lealth a	and Mer	ntal Hy	giene	е		
			1 - State Registrar				Ce	rtificate of	Death			Reg. No	2008	35	972
	Physici		1. Decedent's Name (First, Middle, $11es$	Last) William	Mose	er	SR.			Date of Dea Month	ath Da 29	ay Year 2008	3. Time o	М
1	/Medid Examir		4a. Facility Name (If n	ot institution, (give street and num	ber)		4b. City, Town, o	r Location o		ODEL		. County of Dear		р
					Church R			Boonsb					Washingt	on	
п	Funeral		5. Social Security Num 214-28-091		Sex 1 X M 2 □ F	7. Age (<i>In yr</i> s. la. 7. 7	st birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	Date of Birt (Month, Da	y, Year)	Co	thplace (State ountry)	_
	Director		Usual Residence of D				110.			Sep	tembe	r 2	4, 1931	Maryla	nd
	yland Now			0b. County		10c. City,	Town or Lo	ocation						10d. Inside C	City Limits
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	or 28	Dire	10e. Street and Numb		Church Re	oad		10f. Zip Code	1713			0	itizen of What Co	,	
	death w	neral	11. Marital Status	nevola		lent Ever in U.S.	13.	Was Decedent of H		igin? (Specify	Yes or No-		14. Race - Ame	erican Indian,	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "McGoal Exer" in a last be neutiled at once.	by Funeral Director	1 ☐ Never Married 3 ☐ Widowed 4 [1 X Yes 2 If Yes, Give Year or Da	² □ ^{No} 1950)_	1 □Yes 2 No	Specify:		an, etc.)		Black, White	_{e, etc.} vhite	
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	t and Health tem 27		20a. Method of Dispos					sition (Name of matory or other place		Date			ocation - City or		
Baltimore,	Pages nent of I ant: If ite		1 Donation 5		Removal from St	iale		natory or other plac Lutheran		11_3_	U8	Mazoa	rsville,	Mora 1	and
alti	permit. Departm Importa any inju once.		21. Signature of Fune					2. Name and Addres							anu
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3	/Medical		disease or condition resulting in death)	4	a Due to (o	r as a conseque	nue of):	Car	ice.					16 m	ionth
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Вох	Physician: The law requires that the death certific this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pr in the past 12 mo 1 □ Yes 2 □ N	onths?	4 Pregna	rth 2 ☐ Fetal d ant at time of dea	eath 3	Ectopic pregnancy Other (specify)	y				23d. Date of del Month		Year
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↓	Physici this ce al direc	.0	examiner? 1 ☐ Yes 2 No	ı	Hospital: 1 ☐ In	patient 2 🗆 El	R/Outpatier	nt 3 DOA Othe	ar.				6 ☐Other (Spec	cify)	
0	ding Ph h. After th funeral	J:UC	27. Manner of Death	5 Pending	28a. Date of	Injury 2 , Day, Year)	8b. Time of	28c. Injury Work	y at		Describe h			-	
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Division	or Att after d Direct in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place o building	f Injury - At hom g, etc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. I	Location (S City or Tow	treet an n, State	nd Number or Ru e)	ıral Route Nun	nber,
	e Hospital or Attending 24 hours after death. e Funeral Director: After letely filled in by the funer	<u>ö</u>	29a. Certifier	Certifying	Physician: To the b	est of my knowl	edge, deat	occurred at the tin	ne, date an	nd place, and	due to the	cause(s	and manner as	s stated	
	To the Hosp within 24 ho To the Fune completely f	ledical	(Check only 2[one)	☐ Medical Ex	aminer: On the bas and manne	sis of examination	n and/or in	vestigation, in my o	pinion, deal	th occurred a	t the time, o	date and	d place, and due	to the cause(s	s)
	To the within 2 To the I complet	Σ	29b. Signature and title	e of certifier	0		0	29c. License	number		2	29d. Da	ite signed (Monti	h, Day, Year)	
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34	1-5+1		30. Name and address	of person wh	o completed cause	of death (Item 2	3a) (Type,	Print)	. (-	TIJ	Laa	0 1	trans MA	MP 2	MILE
	Sta	te	31. Date filed (Month,	- 0 4 6	32.	gistrar's Signatur	e Z	and a		,,,,	1491		3 TEWEL	mud	140
	Registra	ar	00	T 3 1 7	2008	dear A	The same of	19482							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT 20, 2008 **Physician** Sarah Marshall 05:40am M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MITCHELLVILLE PRINCE GEORGE'S VILLA ROSA NURSING HOME 8. Date of Birth (Month, Day, Year)

JULY 30 1926 | 9. Birthpiace (June 2)

NEW YORK, NEW YORK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □X Months Days Hours Min Yrs 081-42-9466 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?? Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Medical Examination roust by natified at 1∏Yes 2□No Director PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA HUNTERTON STREET 12002 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 DXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: AFRICAN AMERICAN 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental n and Mental CLIFFORD D. BELLINGER FLORA UNKNOWN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau VANESSA MARSHALL/DAUGHTER 12002 HUNTERTON STREET UPPER MARLBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7 FOREST GREEN CEMETERY 10-25-08 MARLBORO, NEW JERSEY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME of Fureral Service Licens ROAD LANDOVER, MARYLAND 7474 LANDOVER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner ADULT FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 □Yes 2 😾 No 2 🔀 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check o 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 D32261 OCTOBER 21, 2008 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl Richard Feldman 9500 Annapolis Road, Suite A-4, Lanham, MD 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 2 2008 Registrar

Box 68760

P.O.

of Vital Records.

			Pleas	se Type or Prin					_		egible.	
L.		For State Registrar		State of Ma	aryian	•	artment of F ertificate of		-	giene Reg. No.	nns	35071
		1. Decedent's Nam	ne (First, Middle,	Last)					2. Date of De	eath	Vaar	3. Time of Death
Physicia /Medic		ARRIE N	M. MADDO	X-TAYLOR					OCTOB	er 9	200 8	3 /2:38 A M
Examin				give street and number)	~			r Location of Death			unty of Deat	
		5. Social Security		ITY HOSPITA		ast birthday	LANHAM If Under 1 Year	If Under 24 Hrs.	8 Date of Bir			EORGE S
Funeral Director		579-86-2	2583	1 M 2√2 F		38 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da JULY 6	ay, Year) , 1970	Co	HINGTON DC
/land		10a. State	10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
Maria-fish	ctor	MD	PRINCE	GEORGE'S	DIS	STRICT	HEIGHTS					1 X Yes 2 No
or 28	Dire	10e. Street and Nu					10f. Zip Code	_		Ü	of What Co	
s 23a	eral	2414 KIRT	ILAND AV		Ever in 119	2 12	2074	·	ecify Ves or N		D STAT	rican Indian,
filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, I've Medical Evan ener inset by notified at	Funeral Director	 Marital Status Never Mar 	rled 2□ Marrie	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2	No	3.	Was Decedent of H		Rican, etc.)		Black, White	e, etc.
ral",o	d by	3 XWidowed	4 Divorced	If Yes, Give Year or Dates:			1 □Yes 2 X No	Specify:		Sp	ecify: BL	ACK
72 hours "natural"; d'en Eva	Completed	(Spe	15. Decedent'	s Education t grade completed)		(Give	edent's Usual Occup e kind of work done	during most of work	ing	16b. Kind	of Business/	Industry
within ene. than	dmc	Elementary/Sec	ondary (0-12)	College (1-4or 5	5+)	lite.	DO NOT use retired	RSING ASS	T	MID	STNG	
filed Hygi other ent, I	Be Co	17. Father's Name	(First, Middle, L	ast)			110	18. Mother's Name				
uld be Menta rked tic ev	고 B	JOHN	N J. MAD	DOX				EULA M	I. TAYLO	OR		
2 short and is ma	•	19a. Informant's N	Name/Relationsh	ip (Type. Print)		19b. Mail	ing Address (Street	and Number or Rur	al Route Numb	oer, City or To	own, State, 2	Zip Code)
and health		ALECIA N		AUGHTER	John D		PITTS PL		201 WAS		ON D	
ages 'nt of h			Cremation	3 ☐ Removal from State	C	emetery, cre	ematory or other place KE CREMAT	ce) ¦		BELTS	•	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item once.		41 Donation 21. Signature of F	5 □ Other (Sp uneral Service	A	1 411		22. Name and Addre					, MD.
permi Depa Impo any Ir once		1/		complications that cause	all	ley 1	125 MARYT		OTOL MO			20002
eath certificate be executed was attending physician and for use as the burial-transit	sal Examiner	shock, or he Immediate Cause disease or conditi resulting in death Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease o that initiated eveni resulting in death)	ent failure. Tis of (Final ion)) onditions, mmediate lerlying ir injury ts	only one cause on each it	a consequ a consequ	uence of):	Thrombi					Interval Between Onset and Death
the de	Physician/Medica	IF FEMALE: 23b. Was decede in the past 1: 1 □Yes 2 9 □ Unknow	2 months? ☑¶o	23c. If yes, outcome 1	2 Feta	I death 3	☐ Ectopic pregnand ☐ Other (specify)	sy .		230	d. Date of de Month	livery Day Year
w requires that s been signed t should be deta	by		ificant conditio	ns contributing to death b	ut not resu	ulting in the	underlying cause giv	en in Part I.		tobacco use Yes 2□I		o the cause of death?
aw req as beel 2 shou	Completed								24a. Was		24b. Were at	utopsy findings available completion of cause of
The la ate ha	mo;									ormed?	death?	
cian: ærtiflic æctor,	Be (25. Was case reference	erred to medical	11			Lou	26. Place of Deat	th (Check only	one)		
Physi this c	<u>۴</u>	1 Yes 2 2 27. Manner of Dea				ER/Outpation	EIIL 3 L DOA	ner: 4 Nursing Ho	ome 5 ☐ Res			ecify)
ding th. After funer	tion	1 Natural 2 □ Accident	5 Pending investig	28a. Date of Inju (Month, Da ation	ay, Year)	Injury	Wor	k? lYes 2 □ No	Zou. Describe	now injury o	Courred	
or Atter after dea Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6	at he	ury - At ho c. <i>(Specif</i>	ome, farm, s (y)	treet, factory, office		28f. Location City or To	(Street and I own, State)	Number or R	ural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical Co	29a. Ce -r heck only one)		g Physician: To the best xaminer: On the basis and manner si	of examine							
To the within To the Somple	Med	29b. Signature an	d title of certifier	\(\)			290. Licens	se number		29d. Date s	signed (Mon	th, Day, Year)
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Car		30. Name and add		who completed cause of			e, Print)					
90	•	31. Date filed (Mo	1	7 H M N 40 ■ 32. Regist			ELLEVILL	E KOAS	SUTE	B216	BOW	5 HD 20716
Sta Registr		OCT 1	6 2008	Keen W	4	ante						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Julius 16, Mungo October 2008 10:20aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5133 Doppler Street Capitol Heights Prince Georges If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7/13/1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 65 **Director** 247-76-2668 Lancaster, SC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a five fice I Extraction must be invalided at 1X Yes 2 No Director Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 United States 5133 Doppler Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 M No If Yes, Give* Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2KINo Specify. Specify: Black Ś 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver/ Boiler Furnace Boiler Furnace Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Coleman Mungo Leona Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corinne M. Mungo / Wife 5133 Doppler Street Capitol Heights, Maryland 20743 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 10/23/2008 | Lancaster, S.C. Rocky Branch Bapt. 4 ☐ Donation 5 ☐ Other (Specify) Alexanderss of Facility ope, P.A. 5538 Mariboro Pikė/Forestville, Md. 21. Signature of Funeral Service Licens 20747 0 23a. Part 1. Enter the disease, or co shock, or heart failure. List on inplications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 2 No Division of Vital 1 ☐ Yes 2 XNo 1 ☐ Yes r this certifica ral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 12 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 □ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of E Funeral Direct letely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 6

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Year)

Enway

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician Samue1 R. Meriwether 2008 October 0 11:50a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9112 D'Arcy Road Prince Georges Upper Marlboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 577-38-9930 90 Director Aug. 13, 1918 New Orleans, La Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the McClical Examinar must be notified at 1√2 Yes 2 □ No Director Maryland Prince Georges Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9112 D"Arcy Road 20774 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black à If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the the many injury or other traumatic event, the the Elementary/Secondary (0-12) College (1-4or 5+) Naval Research Lab Supervisor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel R. Meriwether un-avail 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9112 D Arcy Rd. Upper Marlboro, Maryland 20744 Randolph H. Kee/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veternas 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Md. 4 Donation 5 Other (Specify) 11/5/2008 21. Signature of Funeral Service Licer de 22. Name and Address of Facility Alexander S. Pope / P.A. 5538 Mariboro Pike/Forestville, Md. 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (er as a consequence of) Examiner 35 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed () ig physician and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.O. TYes 2 No the 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed? Yes 21 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral (28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Funeral Director; After completely filled in by the funer Division Hospital or Attending 1 🔼 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Amir Alikhani MD
31. Date filed (Month, Day, Year)

OCT 2 8 2008

101 Centennial Street Suite B LaPlata Maryland 20646
32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

46046

October 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Joe Lawrence Mayes 10/23/2008 7:00P 4b. City. Town, or Location of Death 4c. County of Death Clinton Prince George's Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Months Days Hours Min. 1 XM 2 ☐ F 1/1/1935 73 Frisco, Texas 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑Yes 2 ☐ No Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country?

/Medical 4a. Facilify Name (If not institution, give street and number) Examiner Southern Maryland Hospital 5. Social Security Number **Funeral** 461-46-4958 Director Usual Residence of Decedent 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Directo Maryland 10e. Street and Number filed within 72 hours after death with 2268 Dawn Lane Temple Hills United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? I⊠Yes 2 ☐ No 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Printer The World Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ဂ္ Kennie Hue Maves Nova Kidd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Helena Mayes / Wife 2268 Dawn Lane Temple Hills, Maryland 20748 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/31/2008 | Cheltenham, Maryland Maryland Veterans 21. Signature of Funeral Service Licent 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to this a consequence of): disease or condition resulting in death) /Medical Examiner ma Sequentially list conditions, il any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Examin Due to (or as a consequence) Syndiame and burial-tran P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown carcinoma coronary Completed peen 24b. Were autopsy findings available prior to completion of cause of death? disease 24a. Was an page 2 s has autopsy certificate 2 210 2 □No 1 ☐ Yes 1 ☐Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2**⊠**No 1 ☐ Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Year

29a. Certifier NC/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

D63183

V-lamon MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHRI KANNAN 7503 CLINTON - MD ROAD

31. Date filed (Month, Day, Year) State OCT 2 8 2008

1 - For State Registrar

Physician

32. Registrar's S

U

Medical

			For State	State of Marylan		ertificate of I		Mental Hyg	giene 1	18 35978
	4		Registrar 1. Decedent's Name (First, Middle, Las	rt)		eruncate of t	Deam	2. Date of Dea	Reg. No.	3. Time of Death
	Physici		77	nson				Month Oct.		Year
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat		4c. County o	
		90	9300 Allentown R			Ft. Wash				Georges
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. 1	la <i>st birthd</i> ay Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Day	, Year)	Birthplace (State or Foreign Country)
-	di la la marita di marita. Il marita di marita		226-34-8041 Usual Residence of Decedent					Dec. 25	, 1928	Virginia
	rylanch how	_	10a. State 10b. County	10c. City	y, Town or L	ocation				10d. Inside City Limits
	ne Ma 8a-f s	Director	MD Prince	Georges Ft	. Wasl	hington				1 ☐ Yes 2 ☑ No
	with the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	•
	eath is 23, must	Funeral	9300 Allentown 1	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H		inecity Yes or No-	USA 14. Race	- American Indian,
S	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		. Was Decedent of H If Yes, specity Cuba		to Rican, etc.)	Black,	, White, etc.
21215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	B1ack
5-	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wo	rking	16b. Kind of Bus	iness/Industry
7	withir iene. than he Me	duic	Elementary/Secondary (0-12)	College (1-4or 5+)		stodian	"	1	Cairfay (Cty Public Sch
	il Hygi other ent, tl	Be C	17. Father's Name (First, Middle, Last)		041	Jeouran	18. Mother's Nar	ne (First, Middle,		
/lar	should be filed and Mental Hygi s marked other umatic event, t	To B	Johnny Manson	n			Rosa Ha	arrison		
Maryland	S S S S		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mail	ing Address (Street a	and Number or Ru	ural Route Numbe	r, City or Town, S	itate, Zip Code)
	1 and 2 Health tem 27 I		Verndel White/Date 20a. Method of Disposition			Allentown		. Washir		
altimore,	Pages nent of hint: If ite		1 XBurial 2 ☐ Cremation 3 ☐	nemovar nom State		osition (Name of ematory or other plac	1			City or Town, State
를	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			Cemetery 22. Name and Addres			Alexandi	ria, VA.
Ba	Dep Imp		1 He Shaun	Uatts		22. Name and Address Murray Fun 4804 Georg	ia Ave.	N.W. Wa		n, DC 20011
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ilications that caused the death one cause on each line.	n. Do not er	nter the mode of dyin	g, such as cardia	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a Malignant Ne	oplasm	n of Prost	ate			Onder and Death
	Examiner			Due to (or as a consequ	uence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	uence of):					
	ecuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
90,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
68760	ficate physi s the b	edical		d						
Box	death certif e attending id for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna					23d. Date	of delivery
	0.0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		□Ectopic pregnancy □ Other <i>(specify)</i>			Mont	
О. О.	at the de l by the stached	hys	9 Unknown							
	The law requires that the te has been signed by the lage 2 should be detache	þ	Part II. Other significant conditions co	intributing to death but not resu	ulting in the u	underlying cause give	en in Part I.			oute to the cause of death?
Š	w require been signature	eted						10		3 Probably 4 ∏Unknown
Vital Records,	sician: The law certificate has l rector, page 2 s	Completed						24a. Was a autops perfor	sy pri	ere autopsy findings available for to completion of cause of eath?
ta			25. Was case referred to medical				26 Place of Dec	1□ Yes	2 ☑ No 1 ☐]Yes 2□No
	Physicia this cer al direct	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Othe	7k.	ath <i>(Check only or</i> lome 5 x Reside		(Specify)
0	ding Ph	Di: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work			ow injury occurred	· · · · · · · · · · · · · · · · · · ·
Sio	tendi leath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
Division or	l or Attenc after death Director:	Certification:	4 ☐ Hornicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Si City or Town		r or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification ompletely filled in by the funeral director,		(Check only 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinat	wledge, dea tion and/or i	th occurred at the tim	ne, date and place	e, and due to the curred at the time, o	ause(s) and man	ner as stated. nd due to the cause(s)
-	o the	Medical	29b. Signature and title of certifier	and manner stated.		29c. License				(Month, Day, Year)
	->-0		8. 2.10	· No		H/0/	0665			21, 2008
•	4	-	30. Name and address of person who	completed cause of death (Item	23a) (Type		1 11		OCCODEL	21, 2000
	Sta	te.	31. Date filed (Month, Day, Year)	hus hi Cina 32. Registrar's Signa	ture	JOSIL CO	July #	200 H	HEGO MI	20774
est.	Registr	_	OCT 2 4 2008	32. Registrar's Signat	Region					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 8:22 AM Alice Julia Montemuro 10 -23-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salishury
If Under 1 Year If Under 24 Hrs. Coastal Hospice at Wicomica the Lake 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth (Month, Day, Yea 5/18/1924 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours 086-18-9302 Director 84 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ms 23a or 28a-f shor Director Maryland Wicomico 1 ☐ Yes 2 🖪 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Justice Avenue 21804 USA Funeral item 27 Is marked other than "natural", or items other traumatic event, the Maxical Examiner man 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after 1 Yes 2 In If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Law Office Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarinda Euphemia Vredenberg ပ Andreas Thiel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun once. 108 Justice Ave. Salisbury, Maryland 21804 Gail McClymont/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/2008 Salisbury, Maryland 4 Donation 5 Dother (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Road Salisbury, Maryland 21804 dompson CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRLANOMA **Physician** disease or condition resulting in death) MRTASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immortate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence offiattending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □ VAR 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 📆 Yo Other: 4 \(\sum \) Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) this 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 □Yes 2 □ No 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Baltimore,

P.O. Box 68760

Records,

Division of Vital |

102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HmAm

31. Date filed (Mont)

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P.U Bap 1703

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Thomas Henry Mogle PM 61 2008 0817 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Salisbury
If Under 1 Year | If Under 24 Hrs. Wicomico Lake 5. Social Security Numbe 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9/13/1924 **Funeral** 9. Birthplace (State or Foreign **1** M 2 □ F Months Days Hours Min. 84 216-16-7441 Maryland **Director** Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Funeral Director Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 29994 St. James Way 21853 USA ortant: If item 27 is marked other than "natural", or Items injury or other traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify: Be Completed by Armv Specify. 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Police Officer 12 Law Enforcement Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Henry Mogle, Sr. Olive Peterson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Noreen E. Mogle/wife 29994 St. James Way, Princess Anne, MD 21853 Baltimore, Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fastern Shore of Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/08 Hurlock, MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOILOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BND **Physician** STAGE DRURNTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d Date of delivery 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Year Month Day 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 24 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes → No 24a Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 | Yes 2 | No ို 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence (ROther (Specify) HOSP (C)Z After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 🗌 Yes 2 No within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Bop 1773 SAUS BULL UP 21802 COASTAL HOSPICE Hansu WAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar OCT 28 2008 Bloomer H.

DHWH 17 HeV 1/2001

homas

			For State	State of Maryland	/ Department of Certificate of	Health and Mental	7000	35981
	Physici	an	Registrar 1. Decedent's Name (First, Middle, Las	"/- 100:10	Certificate of	2. Date		3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give	street and number)	hell 4h. City. Town		ber 26 2008 4c. County of Death	
2	Examili	iei	PENINSULA REGIONA	a Medien Co	enu	salisbury	Wicomit	•
37	Funeral Director	,	5. Social Security Number 6. Se 11	7. Age (In yrs. las	t birthday) If Under 1 Year Yrs. Months Days		of Birth th. Day, Year) 9. Birth Cou	place (State or Foreign ntry)
er er	show		Usual Residence of Decedent 10a. State 10b. County	10c_City,	Town or Location			10d. Inside City Limits
4	with the Maryland a or 28a-f show Le netified at	ector	1110	nico Sa	lisbury			_1 □ Yes 2 □ No
20	th with t	Funeral Director	10e. Street and Number	Avenue	10f. Zip Code	304	10g. Citizen of What Cour	ıtry?
2/10	fter death ritems 23 iner must	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specify Yes oban, Mexican, Puerto Rican, etc	or No- 14. Race - Ameri Black, White,	
003	72 hours after natural", or ite dicel Examine	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No		Specify: B/	ack
215-		Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	upation e during most of working ed)	16b. Kind of Business/In	Lactory
Z 21	filed within Hygiene. other than '	Be Cor	17. Father's Name (First, Middle, Last)		tactory V	18. Mother's Name (First, Mi	iddle, Maiden Surname)	
ettie /	should be filed and Mental Hyg marked other umatic event,	To B	Earl J. M	itchell in	1	aladys	P. Dixor	<u> </u>
	1 and 2 sho Health and em 27 is mo	1	/19a. Informant's Name/Relationship (7)	rpe. Print)	19b. Mailing Address (Stree	et and Number or Rural Route N	lumber, City or Town, State, Zip	1 Code) MD 2184
# altimore,	~~ +- 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ce of Disposition (Name of the entry, crematory or other plane)	4 7	20c. Location - Gity or To	own, State
altin	permit. Pages Department o Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fup ☐ Service Lice is		2. Name and Addr	ess of Facility	1, Jalishu	JAST:
<u> </u>	89 7 6 8	3.4	220 Port 1 Sato Valinger	=elle, S.	BernieSm	rith Functal 1	tome Salisbur	4 Md 21801
	Physician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that caused the death. The cause on each line.		ing, such as cardiac or respirate	ory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer	ice of):	0.15	1	1 Mars D
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen		TIAL PREUMON	1715	8 /RS
Ć.	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):			
8760,	physicia the bur	dical		l				
Box 6	eath certific attending p	an/Me	23b. Was deceder pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de			23d. Date of delive	ery
.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of deal		cy	Month	Day Year
Division of Vital Records, P.O	To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	þ	Part II. Other significant conditions con	ntributing to death but not resulting	g in the underlying cause giv		Did tobacco use contribute to the	
cord	sw requi	Completed					Vas an 24b. Were auto	psy findings available
al Re	: The la icate ha	Com				 8	autopsy prior to condended death?	mpletion of cause of
Ž.	ysician is certif director	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3 DOA Oth	26. Place of Death (Check of	nly one) Residence 6 □Other (Specification of the control of the	
o uc	ding Ph .r. After th funeral	ion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		b. Time of lnjury 28c. Injury Wor	ry at 28d. Descr rk?	ibe how injury occurred	<i>(</i>)
ivisio	I or Attend after death. Director: A I in by the fi	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)]Yes 2 □ No 28f. Locatio	on (Street and Number or Rura	I Route Number,
	spital o			sician: To the best of my knowle	dae death occurred at the ti		Town, State)	
	To the Hospital within 24 hours a To the Funeral I completely filled	ledic	one)	ner: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occurred at the ti	me, date and place, and due to	the cause(s)
	o vit	2	29b. Signature and title of certifier	- A	29c. Licens	se number - 3 - 7 3 4	29d. Date signed (Month, 1	
	362	-	0. Name and address of person who co	mpleted cause of death (Item 23			/ /	
	Stat	e	1. Date filed (Month, Day, Year)	M.D. 100	E. CAY/01/ 3.	T. SALISBURY	MO	
	Registra	ır	OCT 2 8 20	JUB Theren A	T Appelled			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ONEAL ILLIAN 1400M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tate Chesapeake Hospice 5. Social Security Number 6. Sex 7.7. If Under 1 Year | If Under 24 Hrs. Anne House Arundel 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 1 F Months Days Hours Min 88 Director 229-12-0371 6/14/20 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Haryland Prince George's Hyattsville 10e. Street and Number 10g. Citizen of What Country? United States 6905 Shepherd 20784 Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "marked Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OUNSELOF D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hattie Enoch Broadus Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl O'Neal. 12906 Ft. Washington Rd., Ft. Washington, MD 20744

ee of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/24/08 Suitland, Haryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 814 Upshur Street, NW, Hackett Funeral Chapel Washington D.C. 20011 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causeyon each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NGIOSARCOMA MUNTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, has been signer ge 2 should be d þ EVERE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29c. License number

Registrar

State

TILHAR

31. Date filed (Month, Day, Year)

DCT 2 3 2008

W

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

2438

NNAPOLIS MOZIKUI

Pring EXENSE HIGHWAY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** William Ladd Prohaska Sr. Je Hobes 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARL ATA If Under 24 Hrs. CIVUSTA MEDICAL If Under 8. Date of Birth (Month, Day Year August 10, 9. Birthplace (State or Foreign Country) Washington, ocial Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🔀 № 2 🗆 F Months 579-42-6579 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once. 1 □Yes 2171No Maryland Charles Port Tobacco Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20677 7685 Elaine Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No 14. Race - American Indian, 11. Marital Status PROHASKA, WILLIAM Black, White, etc. 1 TYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2KKMarried 1 □Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: White à W II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Builder Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Charles Prohaska Marguerite Ladd ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Ladd Prohaska Jr. / Son 410 Carriage Lane Huntingtown, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Washington Nat. Cemetery 10/17/2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Pay 1. Enter the disease, or compleshock, or heart failure. List only design the complete complete the complete com Immediate Cause (Final **Physician** X WEEK resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical nse s IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a detached f 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1XInpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred I or Attending P after death. Director: After t Injury 1 Natural 5 Pending 1 ☐ Yes investigation 2 Accident filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Dag Year) 29b. Signarole and title of certifier ame and address of person who completed cause of death (Item 23a) (Type, Print 32. Registrar's 31. Date filed (Month, Day, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

			1 - For State Registrar	State of Marylar	id / Depa		Health and	Mental Hyg		35984
	Physici		1. Decedent's Name (First, Middle, Last) Pablo B. Par	raoan				2. Date of Deat October	r, 2008	3. Time of Death 2:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give str Ft. Washington Hos			• • •	or Location of Deat hington	h	4c. County of Death Prince Geo	rge's
Ī	Funeral Director		5. Social Security Number 6. Sex 577−88−3916 1 🖫	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days			9. Birthe Cour 1934 Phili	place (State or Foreign ntry) ppines
	aryiand ahow dat	_	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo		y, Town or Lo				1	Od. Inside City Limits 1 ☐ Yes 2 🕱 No
3	deelit with the maryland me 23s or 28e-f show Finust be notified at	Directo	10e. Street and Number 1008 Lindsay Rd.	orge 3 Oxe		10f. Zip Code 20745		1	0g. Citizen of What Cour	
		by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 13 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Fil	etc.
9500-61717	e fied within /2 hours after al Hygiene. I other than "natural", or ite vent, the Madical Examina	Completed	15. Decedent's Edución (Specify only highest grade Elementary Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Business/In	
≘ .	Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Ambrosio Paraoat	n				me <i>(First, Middl</i> e, <i>M</i> lina Bacn		
Mary	ind 2 should alth and Men 27 ie marke ir traumatic		19a. Informant's Name/Relationship (<i>Typ</i>) Nieves Paraoan / W	ife	1008	Lindsay	Rd., Oxo	n Hill Md		
more,	rages 1 a nent of He int: if item iry or othe		20a. Method of Disposition 1	moval from State Res	Place of Dispo cemetery, crer Surrect	esition (Name of matory or other pla cion Ceme	etery 10/	Date 22/2008	20c. Location - City or To Clinton, Ma	own, State iryland
Dalt	permit. Pages Department of important: if it any injury or o		21. Signature of Funeral Service Licenses					_	alas Funera 11 Maryland	1 Home, P.A 1 20745
	Physician /Medical cieu and pural-transit printing	i Examiner	23a. Part I Inter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection) Due to (or as a consection) Due to (or as a consection)	quence of):	nug	the p)	arevano	Approximate Interval Between Onset and Death
. BOX 68/	inel the death Certilicate be executed ted by the attending physicien and detached for use as the burial-transit	Physician/Medicai	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3	⊒Ectopic pregnand □ Other (specify) _	ey		23d. Date of deliv Month	ery Day Year
ς, L	w requires their s been signed b should be deta	<u>주</u>	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause g	ven in Part I.	1	pacco use contribute to t es 2 ☐ No 3 ☐ Prol	
Hec	Ine law ete hes b page 2 sl	Completed						24a. Was a autops perforr	y prior to co	opsy findings available ompletion of cause of
or vital	nysician: his cartific I director.	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No Ho	ospital: 1 Inpatient 2] ER/Outpatier	II 3 DOA	ther: 4 🗆 Nursing I	ath <i>Ch</i> eck only on Home 5 ☐ Reside	ence 6 □Other (Speci	fy)
uois	Attending Physician: r death. ector: After this cartific by the funeral director.	ation:	27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	iry at ork?]Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
DIVISION	To the Hospital or Attendit within 24 hours effect death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			City or Town		
	ne Hosp in 24 hou he Fune pletely fi	Medical		cian: To the best of my know: On the basis of examination and manner stated.				urred at the time, d	ate and place, and due t	o the cause(s)
;	<i>i</i> 9 € €	Σ	29b. Signature and title of certifier	Teleles	Im	29c. Licer	60 4		19d. Date signed (Month,	
	bil		30. Name and address of person who cor Amir Mirza-Alikani				l., Ft. W	ashington	Md. 20744	
	Sta Registi		31. Date filed (Month, Day Year)	32. Registrar's Sig	awre					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Parker October 2008

Months

4b. City, Town, or Location of Death

Cheverly

| Flunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1. Days | Hours | Min. | 09/16/1942

4c. County of Death

Prince George's

Birthplace
 Country)

Alabama

(State or Foreign

10d. Inside City Limits

Physician /Medical **Examiner**

1 - For State Registrar

10a. State

Willie

5. Social Security Number

422-56-0061

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

Prince George's Hospital Center

6. Sex

1 🔀 M 2 🗆 F

7. Age (In yrs. last birthday)

10c. City, Town or Location

66

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Examiner physiclan and s the burlal-tran Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the I

ctor	D.C.			Washi	ngton						1 □Yes 2 🔀 No
<u>Sire</u>	10e. Street and Nu	mber	· · · · · · · · · · · · · · · · · · ·		10	f. Zip Code			10g. C	itizen of What Co	ountry?
ᆵ	4800 E	. Capitol	St.,N.E.	# 111		2001	19			ī	I.S.A
nue	11. Marital Status		12. Was Decedent E Armed Forces?		13. Was I	Decedent of Hi , specify Cuba	ispanic Origin? (S ın, Mexican, Puer	Specify Yes or to Rican, etc.	No-	14. Race - Ame Black, Whit	
Be Completed by Funeral Director	1 Never Marr	ied 2⊠ Married 4 □ Divorced	1 ∏Yes 2 N If Yes, Give Year or Dates:	0	1 □ Y	es 2.MiNo	Specify:			Specify: B	•
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		(First, Middle, Last,					18. Mother's Nar	me (First, Mic	ldle, Maidei	n Surname)	
မှ	David			15.		1 (0)		retta (
		ame/Relationship (1			and Number or Ri		-		
	20a. Method of Dis	Parker/W	ire	20b. Place	of Disposition	(Name of	N.E. #	Date		ocation - City or	
		□ Cremation 3 □ 5 □ Other (Specif	Removal from State	1	tery, cremator Lincoli		· · · · · · · · · · · · · · · · · · ·	23/08		-	
		uneral Service Licer		1 2 0 0					DIE	-	Maryland
	K)	arry of	har	Y	492	Burro	ington bughs Ave	& Sons N.E.	. Wash	ington.	D.C. 20019
	23a. Part 1. Enter t	he disease, or com	plications that caused one cause on each line	the death. D							Approximate Interval Between
ì	Immediate Cause disease or condition	(Final	a Fatal (c Arrhy	/thmia					Onset and Death
	resulting in death)		Due to (or as a	consequenc	e of):	and the latest the lat					
_	Sequentially list co	nditions,	Renal 1								
nine	Sequentially list co cause. Enter Unde Cause (Disease or	erlying injury	Due to (or as a	consequenc	e or):						
xar	that initiated events resulting in death)		cDue to (or as a	consequenc	e of):						
cal			_ d.								
Medi	IE EELAN E										
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? □No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal dea		ppic pregnancy er (specify)	/		_	23d. Date of de Month	livery Day Year
Ph)			ontributing to death but	t not resulting	in the underly	ing cause give	en in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
ted by								1			robably 4 🖳 Inknown
ble								24a. V	Vas an utopsy	24b. Were a	utopsy findings available completion of cause of
5								1 □ Ye	erformed?	death?	2 □No
Be	25. Was case refer examiner?	71	Hospital:			Tou	26. Place of Dea				
<u></u>	1 Yes 2 ☐ 27. Manner of Deat		1 Inpatier		Outpatient 3	T	4 LI Nursing F			6 ☐ Other (Spe	ecify)
io Lio	1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day)	Year) 200	. Time of Injury	28c. Injury Work	∕at ? ∕es 2 □No	28d. Descri	be how inju	iry occurred	
ii ca	3 Suicide	6 Could not be determined		y - At home,			163 2 110	28f. Locatio	n (Street a	nd Number or R	ural Route Number,
je i	4 Homicide	determined	building, etc.	(Specify)				City or	Town, Stat	e)	,
Medical Certification: To	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of nIner: On the basis of and manner stat	examination:	ge, death occi and/or investig	urred at the tim ation, in my op	ne, date and place pinion, death occu	e, and due to urred at the til	the cause(me, date ar	s) and manner and place, and due	s stated. e to the cause(s)
ĕ S	29b. Signature and	title of certifier	1			29c. License	number		29d. Da	ate signed (Mont	th, Day, Year)
		-	Mark			D58	3957		10	0/16/08	
	30. Name and addr	ess of person who	completed cause of de	ath (Item 23a	(Type, Print)		, , , , ,				
	Mary	Liztle,M	.D. 3001 H	ospita	l Drive	e,Cheve	erly, Mary	land 2	20785		

State Registrar

31. Date filed (Month, Day, Year) 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** OCTOBER 17 2008 ear JOSEPH PERKINS 6:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 8. Date of Birth JAN 10 Social Security Number 7. Age (In yrs. last birthday) e (State or Foreign **Funeral** Year) 26 1 € M 2 □ F Months Days Hours NORTH CAROLINA 242-22-0287 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 TyYes 2 No MD MONTGOMERY SILVER SPRING the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20905 USA 2201 NEES LANE Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1≦]Yes 2 □ No ARMY
If Yes, Give
Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be 1 and 2 should be I Health and Mental UNKNOWN SARAH DAVTS ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Heatth an Important: If item 27 is any injury or other trau 15700 CHESWICKE LANE UPPER MARLBORO, MARYLAND 20772 NORBERT PERKINS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Gremation 3 ☐ Removal from State MD VETERANS CEMETERY 10-27-08 CHELTENHAM, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Floor ral Service Licens e J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCLEROSIS HEART DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No Ö the 9 Unknown 9 Unknown σ. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð þe No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? 1 Yes 2 No certificate ueatii? 1 □Yes 2 🖺No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40064588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K Year) 1500 Forest Glen Rd. Silver Sp. 20910 Tolia 31. Date filed (Month, Day, State OCT 2 1 2008 Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 16, 2008 Delores Barbara Queen 4:15 P.Mw 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital 7. Age (In yrs. last birthday) **74** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 04/26/1934 9. Birthplace (State or Foreign 5. Social Security Number Phil., Pa. Days Min Hours 1 □ M 2 🔀 F 215-38-5677 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 TxYes 2 □ No Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20774 1413 Canadian Geese Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. African-1 Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Clerk Department Store 18. Mother's Name (First, Middle, Maiden Surname) Mary Williams 17. Father's Name (First, Middle, Last) Thomas Frank Queen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1413 Canadian Geese Ct., Upper Marlboro, Md. 20774

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

Completed by Be ည Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a. State

Md.

19a. Informant's Name/Relationship (Type. Print)

№ Burial 2 Cremation 3 Removal from State

Brian K. Queen/Son

20a. Method of Disposition

Funeral

Director

ns 23a or 28a-f shumst be notified a

Funeral Director

the Maryland

death with

filed within 72 hours after

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

of Health and Mental Hitem 27 is marked of rother traumatic ever

- i

Physician/Medical Examiner as the burial-tran attending p signed by the a ģ icate has been si, page 2 should b Medical Certification: To Be Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Har	mony Mem.	Park 10	0/24/0	8 Lan	dover,Ma	ryland	i
21. Signature of Funeral Service License	1. Crati	22. Name a	s Washi high Burroughs A	on & S Ave.,N	ons Co., I.E.,Wash	Inc. ington,D	.C. 20)019
23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.	Do not enter the mo	de of dying, such as ca	ardiac or res	spiratory arrest,		Approximate Interval Better Onset and	etween
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	c She	cla					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque							
that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of de	death 3 Ectopic				23d. Date of deliv		Year
Part II. Other significant conditions con	stributing to death but not result	ing in the underlying	cause given in Part I.		23e. Did tobacco u 1 □ Yes 2		797.4	death? Unknov
Sein M	me D	posa	21	_	24a. Was an autopsy performed? 1 □Yes 2 Zwo	death?	impletion of o	availab cause o
25. Was case referred to medical	11/		26. Place of	f Death (Ch	eck only one)	•		
examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 🔀 Inpatient 2 🗌 E	R/Outpatient 3 🗆 D	OA Other: 4 Nursi	sing Home	5 Residence	6 ☐ Other (Speci	ify)	
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No		Describe how injur	ry occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ry, office	28f. L	ocation (Street ar City or Town, State	nd Number or Rur e)	al Route Nun	nber,
	sician: To the best of my knowner: On the basis of examination and manner stated.							s)

29c. License number

D45660 Doinder Singh, M. D

20b. Place of Disposition (Name of cemetery, crematory or other place)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

300

29b. Signature and title of certi

30. Name and address of pers

OCT 2 0 2008



n who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician OCTOBER 27 2008 5:50 \mathbf{A} M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARCH 4, 1909 REPUBLIC OF PANAMA 1 **X**M 2□ F 214-38-7589 **Director** 99 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. In the first 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 XNo MARYLAND QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 BARREN RIDGE ROAD Funeral 21619 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 DENTIST DENTISTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES RODNEY ဥ MARY BLANCHE MCKENZIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROY RAFTER/POWER OF ATTORNEY 206 BARREN RIDGE ROAD, CHESTER, MARYLAND 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State OCTOBER 30 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 2008 HALETHORPE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 10cm 10 (910) /Medical Due to (or as a ors quence of): **Examiner** Wen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of a The law requires that the death certificate be executed physiclan and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown icate has been si r, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 1 ☐ Yes 2 🖺 1 TYes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 2 No Impatient 1 ☐ Yes 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Only basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the control o 29a, Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

31. Date filed (Month, Day, Year)

29b. Signature

32. Registrar's Signature

Completed cause of death (Item 23a) (Type, Print)

29d. Date signed, (Month, Day, Year)

			For State Registrar	State of Ma	ıryland /		artment of H <i>rtificate of L</i>			giene leg. No.	008	35989
	Dharaisi		Decedent's Name (First, Middle, Last)		_				Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Mary Jane Robert						October		2008 ^{ear}	12:22 A. M
	Examin	er	4a. Facility Name (If not institution, give s Prince George's		Contor		4b. City, Town, or Chever	Location of Death			unty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9. Birth	place (State or Foreign
	Director		370-14-0030] _{M 2} [¥ _F 95		Yrs.	WOTHIS Days	Hours Mill.	097297	1913	Charl	otte, N.C.
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary Fed o	ż	Md. P	.G.	Fai	rmou	nt Height	s				Y Yes 2 □ No
	or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	
	ath wi		602 59th Avenue			140.1		20743	- '/- W N-		U.S.A	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a fit office Exp. in or must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1			Was Decedent of Hi fYes, specify Cuba 1 □Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify: B]	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation e completed)	16	(Give	dent's Usual Occupa	luring most of work	ing [16b. Kind o	of Business/Ir ential	Business
121	vithin ane. than "	Completed	Elementary/Secondary (0-12)	2 Years	+)		no NOT use retired				ior De	
۵ 2	filed v I Hygid Sther ent, II	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle,	Maiden Sur	name)	
<u>Ian</u>	uld be Venta Irked Itic ev	To B	James Daniel Ing	ram				Lou Be	lle Kimn	nons		
, Maryland 21215-0036	tnd 2 sho alth and I 27 is ma er trauma		19a. Informant's Name/Relationship (Ty Mattie Wilkerson/G				ng Address (Street a				wn, State, Zi 20785	ip Code)
Baltimore,	Pages 1 ament of He ant: If item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State	20b. Place ceme Arlin	gton	sition (Name of natory or other place Nat 1. C	em. 10/2		Ft. M		own, State Lrginia
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	& Ona	U	4	Name and Address 925 Burro	shington oughs Ave	& Sons (Co.,In Washin	nc. ngton,I	o.C.20019
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused ne cause on each lin	e.					rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			IAC A	KKTHY,	MIA		-	
	Examiner			Due to (or as a	a consequenc	e oi).						
	p . <u>∺</u>	iner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Die to (or es a	a consequenc	e offic						,
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequenc	e of):						
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289	tificating phy as the	ledic		4.				17-27				
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours affect death. To the Funeral Director: Affect this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	/		23d	. Date of delined Month	very Day Year
ν, σ.	s that ned b	by Ph	Part II. Other significant conditions con					en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
ğ	w require s been sig should b	ed b	CONSESTIVE	HEART	1-A	1201	ZE		1 🗆 Y	es 2 N	No 3□ Pro	obably 4 Unknown
၁၁	law re nas be	Completed	ASTHMA	, , , , ,					24a. Was autop	sy	prior to c	topsy findings available ompletion of cause of
a H	ilcian: The law certificate has ector, page 2 s		HYPERTER	1510N					1 □ Yes		death? 1 ☐ Yes	2 □No
Ĭ	slciar certif	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	ent 2⊠ ER/	Outpation	ot 3 🗆 DOA Othe	26. Place of Deat	th <i>(Check only o</i> ome 5 ☐ Resid		Other (Case	36.1
o T	ding Physician: h, After this certific funeral director,	n: T	27. Manner of Death	28a. Date of Injur	ry 28b	o. Time of			28d. Describe h			aiy)
Š	endin eath. or: Aff he fur	atio	1 Natural 5 Pending investigation				M 1 🗆	Yes 2 □ No				
Ž	il or Attenc after death Director: d in by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tox		lumber or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ledical C	29a. Certifier (Check only 2 Medical Exami	sician: To the best oner: On the basis of								
1_	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner sta			29c. Licens				igned (Month	
	≒ .≱ ₽ 8		255. Signature and title of certifier	The	. /		N -	11-4		10/	17/10	2
	2		30. Name and address of person who co	ompleted cause of de	eath (item 23)	a) (Type,		CHEVER	LY MS	ے۔۔۔	1725	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	han	61		- J - 1-LJ		-,	
	Registr	ar	OCT 2 2 2008	About	15 /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2104 **Physician** SAMES 10 7)8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CUTR MARY WAND MED If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 X M 2 □ F 78 Washington, D.C. 578-34-0757 Director Dec. 08,1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Smithsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21783 U.S.A. Funeral 115 Rachels Court 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cent of Health and Mertal Hygiene.
Int: If item 27 is marked other than "natural", or Item
INT or other traumatic event, The Modical Experiment 1 XYes 2 No If Yes, Give Year or Dates: 52-56 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Beverage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ James Leroy Raley, Sr. Margaret Louise Edinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Margaret Raley/Wife 115 Rachels Court, Smithsburg, Md 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iten any Injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Oct. 17,2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Ave. Boyly Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAN Rugers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final HEMORRHAGEC 6 Hours **Physician** disease or condition resulting in death) /Medical COAGULOPATHY Due to (or as a consequence of): **Examiner** 36 Hours ONSUMPTIVE AND DISSEMINATED INTRAVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner o Hours Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit NECROTIC SMALL BOWEL Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 3 WEEKS Physician/Medical ECROTIZING PANCREATITIS attending pl IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DRONARY ARTERY 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2∐No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

AYANBULE, 31. Date filed (Month, Day, Year) 0CT 1 6 2008

29b. Signature and title of certifier

(Check only one)

GREENE ST BALTIMORE MD 21201 MD . Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

completely

within 2 To the I

29c. License number

NPI 1932243326

29d. Date signed (Month, Day, Year)

12/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20-2008 Month -21:40 PM **Physician** Sarah Rivera /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Clinton Southern maryland Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5-24 9 Birtholace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 49 **Funeral** Months Days 1 □ M 2 F 079-26-5976 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 No MD Charles Waldort **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 19522 Laviat Place 20601 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes Who If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2**√2M**o Baltimore, Maryland 21215-0036 0 Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item Me once. Elementary/Secondary (0-12) College (1-4or 5+) SUDEVVISOV BHO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be white OFFIE Delestor Mary ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) waldorfimb 20601 Vernon Barmore Igrandson 19522 Lariat Place 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition Burial 2 Cremation Greenheld Cemetery 10/27 Hempstead 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility 814 Upshur Wash, DC ZOOI 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATHERUCLEROTIC CARDIOVAKULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORUNANY ARTERY
Due to (or es a consequence of): DICEARE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 3 Probably RENAL 1 🗌 Yes 2 🗌 No STAGE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an IPID DICORD autopsy performed certificate 1 □Yes 2 □No 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes No 1 Inpatient 2 PER/Outpatient 3 DOA After this 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending in 24 hours arter control in Euneral Director: Aff 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILE MATAZAN MD

HOSDITAL

AND

32. Registrar's Signature

D50689

CENTER 7503

2112008

RD Chintrama

20731

SURRATIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of State Of Registrar	viaryiand / Dep <i>Ce</i>	ertificate of L			leg. No. 🤰 (108	35	992
	Obveisi		1. Decedent's Name (First, Middle, Last)				Date of Dea Month	th Day	Year	3. Time o	f Death
	∘Physicia /Medic		James Alfred Roy, Jr.				Oct. 21	, 2008		2:55	A M
	Examin	er	4a. Facility Name (If not institution, give street and numb	•		Location of Death		4c. County			
, pl			Washington Adventist Hosp		Takoma P	ark If Under 24 Hrs.	0 D-4(D:4)	Monte			au Fausieus
	Funeral Director		226-66-0874 ^{1໘M 2□ F}	Age (In yrs. last birthda) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 3	, 1951	Coui	place (State entry) ginia	or Foreign
	ryland	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		-		1	10d. Inside C	
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	F or the	E C	10e. Street and Number		10f. Zip Code			10g. Citizen of		ntry?	
	ath w	Ta.	11407 Keystone Avenue		20735			U. S. A			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, if a Medical Examinar must be notified a once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	No	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Bla	ck, White,	can Indian, etc. Lack	
21215-0036	in 72 ho n "natur Jenical J	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	cedent's Usual Occupa ve kind of work done o . DO NOT use retired	lurina most of worki	ng	16b. Kind of B	usiness/In	dustry	
212	yiene r tha	E	Elementary/Secondary (0-12) College (1-4		al Supervi	sor		U.S.	Post	al Ser	vice_
	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	·		18. Mother's Name			ne)		
<u>lar</u>	uld be Mental rrked c	10 E	James A. Roy, Sr.			Drusilla	Willia	ms			
Maryland	2 should and Mei is marke raumatic		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street a	and Number or Rura	al Route Numbe	r, City or Town	, State, Zij	p Code)	
	and 2 ealth n 27 i		Sylvia Roy - Wife		07 Keyston						
Baltimore,	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify),	ite	position (Name of rematory or other place ction ceme	i	0ate 4-2008	20c. Location	-	own, State	
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Fune (al Service Licensee		22. Name and Addres	ss of Facility Bel	l & Johns	on Funera	al Home	e, P. A.	
		11	23a. P 1 Enter the disease, or c mr leations that caush ch, or heart failure. List o ly ne cause on each	sed the death. Do not e			-			Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition	Sep	SIS					Onset and	Death
	/Medical		resulting in death)	as a consequence of):							
	Examiner	.	Sequentially list conditions b.	Arm	mal (COIS	5				
	P #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury	as a consequence of	\ 0 = 4	1	F				
	ecute and trans	Examiner	that initiated events C.	10 3700	£ 842	2M	101/1	JVX.	<u>, </u>		
60,	tificate be executed ig physician and as the burial-transit		Due to (or	as a consequence of):							
68760,	cate physi the b	edical	d						-		
9 X	certif Iding Se as		IF FEMALE: 23c. If yes, outco	me of pregnancy				23d Ds	ate of deliv	verv	
Вох	atter for u	Physician/M	in the past 12 months?	th 2 Fetal death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	y			onth	Day	Year
o.	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown								
ds, P.	Attending Physician: The law requires that the death certificate be executed reteath. The third attention of the etors. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to dea	h but not resulting in the	underlying cause give	en in Part I.		bacco use con es 2 □ No		the cause of	
Ö	w requir	etec					24a, Was a		Maro out	opsy findings	- available
Be	he lav e has ige 2	Completed			- News		autop perfor	med?	prior to co death?	ompletion of	cause of
ta	an: T tificat or, pa		25. Was case referred to medical			26. Place of Deatl		2 40	1 ☐ Yes	21CINO	
>	yslciz s cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inc	oatient 2 ☐ ER/Outpat	ient 3 DOA Othe				her (Spec	ifv)	
0	g Phy er thi	n: To	27. Manual of Death 28a. Date of		of 28c. Injur	v at	28d. Describe h				
<u>io</u>	ath. r: Aft	atio	1 Natural 5 Pending (Month, 2 Accident investigation	Day, rear)		Yes 2 □ No					
Division of Vital Records,	l or Atter after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place or building	Injury - At home, farm, s , etc. (Specify)	street, factory, office		28f. Location (S City or Tow		ber or Run	ral Route Nur	mber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Co	29a. Certifier (Check only one) 1. Certifying Physician: To the base and manner and ma	is of examination and/or							(s)
	To the I within 2 To the I complet	Mec	29b. Signature and title of pertitles	stateu.	29c. Licens	e number		29d. Date signe	ed_(Month,	Day, Yeal)	
B	F S F S		1000	216	0	454	71	10	12	1/6	200
B	J & C		30. Name and address of person who completed cause	of death (Item 23a) (Typ	e, Print)	Word	h-pto	n	Ad	v. H	ASP.
	Sta Registr		31. Date filed (Month of 8 Year)	Istrar's			,				

			for State Registrar	State of Ivia	iryland / Depa <i>Cel</i>	artment of H rtificate of L			g. No. 2	9 35993
	Dhysisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Yea	3. Time of Death
4	Physici /Medic		Evelyn Delia	Shay				oct	29 200	8 5pm M
	Examin		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
and the			Washington Cou			Hage	rstown		Wash	ington
н	Funeral		Social Security Number 6. S	Sex 7.Age I□M 2 X∷X F	(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. 1	Birthplace (State or Foreign Country)
	Director		216-16-4425 Usual Residence of Decedent		04			July 10,	1924	Maryland
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	ţ	Maryland Washing	7+on	Uaga	erstown				1XXes 2 □ No
	r 28a	Director	10e. Street and Number	31011	пау	10f. Zip Code		10	g. Citizen of What	Country?
	h with		11 W. Baltimore	st. Apt.	G27	2	1740		US	SA
	deat ms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?			ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No-		merican Indian,
9	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the findle Examiner must be notified at	/Fu	1 Never Married 2 Married	1 □Yes 2 XN	0	1 □Yes 2 ☑ No	Specify:	riloan, etc.)	Specify:	
003	urai",	d by	3 X Widowed 4 □ Divorced	Year or Dates:	*					White
215-0036	"nate	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done of	ation <i>during m</i> ost of worki f)	ing 1	6b. Kind of Busine	ss/Industry
212	iled withir Hygiene. ther than	E C	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Flower Te			Flower	Shop
d 2	filed Hygi other ent, t		17. Father's Name (First, Middle, Last)		1.000	18. Mother's Name	(First, Middle, M		01100
lan		To Be	Robert James	Winebrener			Mary	Evelyn	Meekins	
Maryland	d 2 should be fi th and Mental I 7 is marked of traumatic eve	_	19a. Informant's Name/Relationship			ng Address (Street a	and Number or Rura			e, Zip Code)
	7 ± N +		Allen Shay - Sor	n	1625	0 McGrea	or Dr. Ha	aerstown	. Marvlar	d 21740
re	ss 1 and of Healt Item 2 r other		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	e) [Date 2	Oc. Location - City	or Town, State
Ē	nit. Pages artment of l ortant: If Its injury or o		1 Dop ation 5 Other (Speci				i	.2008 Ha	agerstown	, Maryland
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee			refatity Home			21795
<u> </u>	Dep Imp any any		ing led	£						t, Maryland
			23a. Part 1. Enter the disease, or com shock, or neart failure. List only	plications that caused one cause on each line	the death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Mula	ry Inset	Wheetin	gn)			2845
أنخل	/Medical Examiner		resulting in death)	Due to (omas a	consequence of):					a done
п	_xummo.	J.	Sequentially list conditions,	b. Due to (or as a	consequence of):	. /				109)
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	H	WIE 1944	ed In	· Pure			2 day
	execun and al-tra	Exa	that initiated events resulting in death) Last	c. Due to (or a	consequence of):	/				2 12-12
68760,	rificate be executed 1g physician and as the burial-transit	ledical		d	Mybrall	and the second				Jags
89		/edi			/					//
Box	leath cert attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy	V		23d. Date of	
O. E	e dea he at ied fo	Physician/N	in the past 12 months?	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify)	,		Month	Day Year
P.(d by t	Phy	9 Unknown		A mad manufalm min the service	adaylıdaş aşıyaş giye	en in Dort I	23a Did tob	acco uso contributo	to the cause of death?
S,	The law requires that the death cer arie has been signed by the attendir page 2 should be detached for use		Part II. Offier significant conditions	is alse		mako.	sirili Faiti.			Probably 4 Unknown
0	requ been hould	eted		/		- 7,00				
3ec	e law has t	Completed by		,				24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of
a	77							1 □Yes 2	XINo 1□Y	es 2 No
Ξ	Physician: this certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		ot a DOA Othe	26. Place of Death			
of	Physic this stal di	: To	27. Manner of Death	28a. Date of Injur	nt 2 ER/Outpatier y 28b. Time of	IL 3L DOA	4 LI Nursing Ho	me 5 ∐ Resider 28d. Describe hov	nce 6 Other (S	pecify)
o	Attending r death. ector: After by the fune	tior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day,	Year) Injury	Work	? Yes 2 □No			
Division of Vital Records,	Atter	ifica	3 Suicide 6 Could not b	Zoe. Flace of Injul	ry - At home, farm, stre	eet, factory, office	1	28f. Location (Stre	eet and Number or	Rural Route Number,
ă	ai or s afte ii Dir	Certification: To	4 Li Homicide	building, etc.	(Specily)			City or Town,	State)	
	Hospital or 24 hours affe Funeral Dir tely filled in			nysician: To the best o						
	the hin 2 the	Medical	one)	and manner stat						
_		<	29b. Signature and title of certifier	had un		29c. License	G C C	29	d. Date signed (Mo	7008
7	an A		* /iiiiuq a	עוון ן יותו	oth (Hom 00=) /T	() 366	ددر		-1 -1	2004
_	3		30 Name and address of person who	Completed cause of de	eath (Item 23a) (Type,	200 H	1855 Agestin	N, MD	21740	
	Sta	te	31. Date filed (Month Day, Year)		r's Signature	1	4	1 1100		
	Registr	-	OCT 9 U Z	000	as to A					

State of Maryland / Department of Health and Mental Hygiene

Dorse Elmires SHUEY Analysis of the Construction of the Constru				1 - State Registrar	State of Ivial		tificate of L		Re	eg. No. 🤈 🕦 [18 35001
Second processing Number Part P				1. Decedent's Name (First, Middle, Last) Doris Elmira SHUEY					2. Date of Death Month October	Day Ye	ar
Second Secondly Number Second Sec										4c. County of [Death
The State 150 Court 150				5. Social Security Number 6. Sex 1 1 1 1	7. Age (If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, June 25,		Birthplace (State or Foreign Country)
Security Security		yland how			1	Oc. City, Town or Loc	cation				
Security Security		he Ma 28a-fs	ecto	-		На			140	Oc. Citizen of Miles	
Security Security		3a or	a Dir	ATEXAIIG)		-	t Country :
Security Security	30	s after deat ", or items ?	oy Funer	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give				pecify Yes or No- Pican, etc.)	Black, V	Vhite, etc.
Security Security	20-01	hin 72 hour e. an "natural Medical E	pleted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced (Give	lent's Usual Occupi kind of work done o OO NOT use retired	ation during most of work)	king		ess/Industry
Security Security	7	ed witl	Com	9		lau	ndry			<u>-</u>	
20a. Michod of Disposition 1/28ural 2 Cleration S Date 20b. December Cledar Lawn Mem. Park 10/31/08 Hagerstown, Maryland 21. Signatural Service Ligospee 22b. Name and Address of Facility MINNICH FUNERAL HOME 22b. Teffit Enter the disease, or complicificors that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. 22b. Teffit Enter the disease, or complicificors that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. 22b. Teffit Enter the disease, or complicificors that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. 22b. Teffit Enter the disease, or complicificors that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. 22c. If yes, outcome of pregnancy 1			o Be		ars						
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Physician Medical Examiner Framiner Framiner Framiner Frame of particular physics of	E,	1 and 2 Health sm 27 i									
Physician Medical Examiner: Examiner Examiner From the disease or obspice of the state of the	TOL	Pages ent of I nt: If ite y or of		1 DXBurial 2 □ Cremation 3 □ Rem	noval from State						
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Physician Medical Examiner Part				23 . Fart 1. Enter the disease, or complice shock, or heart failure. List only one	tions that caused the cause on each line.					-	Approximate Interval Between
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (bleases or injury) that inhibited events resulting in death) Last Due to (or as a consequence of):	- 1			Immediate Cause (Final disease or condition	10	abetis	Me	b. tus			Onset and Death
The part of the pa					Due to (or as a c	consequence of):	Sion				
Second Second		D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a o	nsequence of):	1				
Was decedent pregnant in the past 12 morths? 23d. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of death 23d. Date of delivery	ć,	oe execute cian and urial-trans		Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	(0)				
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Complete to the complete to the control of the co	. בסכ	ie death certi the attending hed for use a	/sician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tir	☐ Fetal death 3 ☐		/			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)		mat tr			buting to death but r	not resulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
28. Place of Injury - At home, farm, street, factory, office 28. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	20 -	equires en sigr							1 ☐ Ye	s 2 □ No 3 □	Probably 4 Unknown
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)		g Pnyster this neral di	n: To	27. Many of Death	28a. Date of Injury	28b. Time of	28c. Injury	at			Specify)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		or Attendin ter death. Irector: Af In by the fur	rtificatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre	M 1 🗆 1		28f. Location (Str. City or Town,	eet and Number o State)	r Rural Route Number,
Jan 3060396 10/29/08	<u>.</u> :	Hospital 24 hours a Funeral E stely filled i		(Check only 2 Medical Examine	r: On the basis of ex	camination and/or inv	occurred at the ting	ne, date and place pinion, death occur	, and due to the ca	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
		orme within: To the compl∈	Mec		and mainer stated			/		od. Date signed (M	Ionth, Day, Year)
31 Data filed (Month Day Year) 32 Begistrar's Signature	7		-		pleted cause of deat	h (Item 23a) (Type, F				ct	
	9t			31. Date filed (Month, Day, Year)	32. Registrar's	Signature		1	ctorn	an_	21746

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008

					iviai yiai				Death		,	Reg. No.	000	Û	933	-	
			1. Decedent's Name (First, Middle,						2. Dete of Deeth Month Dey Ye			3. Time	of Death	_			
	Physicia		Vera M Sowers									0, 2008	Year	5:45 P.M.			
£	/Medic Examin		4a Fecility Neme (If not institution, give street end number)						4b. City, To	wn, or Lo	cation of Deat	h 4c. Coun	y of Death			_	
•	LAUITIII	Ç.	Sacred Heart Home Hyattsville Prince George's												S		
	Funeral			Social Security Number 6. Sex 7. Age (In yrs. lest birthday)				er 1 Year	If Under	24 Hrs.	8. Date of Bit (Month, Da						
	Director		220-28-5312	1□M 2ÅF	75	Yrs.	Months	Deys	Hours	Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) Nov. 25,1932 Takoma Park						
			Usuel Residence of Decedent														
	itled with 72 hours after death with the Maryland Hygiene, if them 23e or 28e-f show ither than "naturel", or items 23e or 28e-f show ent, the Medical Examiner must be notified at		10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Lim														
		흱	Maryland Prince George's Greenbelt 1™Yes 2□No												es 2∐No		
		9	10e. Street end Number				10f. Z	ip Code				10g. Citizen of	What Cour	ntry?			
1		Funeral Director	14-V3 Ridge Road 20770 USA														
		ne	11. Maritel Status	12. Was Decede	ent Ever in L	I,S. 13	Was Dec	edent of	Hispenic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 14. Ra	ce - Americ		,		
2	or its		1 Never Married 2 Married	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give			1 Yes 2 No Specify:						√ White				
2	ours	2	3 ☐ Widowed 4 ☒ Divorced		10.00					Эресі	y. Whi	, white					
, maryiand zizio-u	n /2 hours *naturel', edical Exu	Completed	15. Decedent's	ecedent's Education 16e. Decedent's Usue y highest grede completed) (Give kind of wor					petion during mos	t of work	ing	16b. Kind of I	d of Business/Industry				
		힏	Elementary/Secondary (0-12)	College (1-4	or 5+)	life	(Give kind of work done during mos. life. DO NOT use retired) Book Keeper					A	counting / NSW				
	Y Qie Y	3		2			Воо	k Ke						/ NS	WC		
	iould be filed within I Mental Hygiene. Perked other than " netic event, the Me	Be	17. Father's Neme (First, Middle, La	•					18. Moth	ers Name	e (First, Middle	, Maiden Suma	me)				
	Men	2	Holmes Thomas Ga	rner								n Willi				_	
	end end is m		19a. Informent's Name/Relationship				-					er, City or Towl		Code)			
	n 27		Ann Sowers / Dau	ghter	1				ive,	Elkr:		D 21075				_	
5	or off		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta		Place of Dis cemetery, cr	position (iva	ame or other pla	ice)	į	Date	20c. Location					
	parmit. Peges 1 end 2 should be flied within Department of Heelth end Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Monce.		4 ☐ Donation 5 ☐ Other (Spe			tropo	litan	Cre	mator	y 1	0/22/08	Alexan	dria,	Virg	ginia		
Danimor	Departiment Import Import Information		21. Signature of Funeral Service Lic	enseg			22. Name a	nd Addr	ess of Facili	ty		/720 B		CAMBROON OF	**************************************		
	207 2 9	9	· Cus	X) 8		G	asch'	s Fu	neral	Home	e. P.A.	4739 B Hyatts	ville	. MD	20781		
	1000		23a. Part1. Enter the disease, or co	mplications that cau	sed the deat								1	Approxir Interval I		5	
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5	no p	2 /															
	requires that the death cer been signed by the ettendir should be datached for use	Physician/		d								-				_	
	he ed for for	Sic	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death						
	atact	윤	Diverticulosis								1 ☐ Yes 2 ₺ No 3 ☐ Probably 4 ☐ Unknow						
ה ל	g ge g	٦	DIVELLICATOSIS										1				
5	nee s	<u>8</u>	Failure to Thrive								24a. Was an eutopsy performed? 24b. Were autopsy finding available prior to completion of cause						
נ נ	as be										completion of of death?						
	s cartific director	Completed	Osteoporosis								1 🗆	Yes 2⊠No	10	Yes 2	2□ No		
9			25. Wes case referred to medical 26. Place of Death (Check only one)												_		
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month /O **Physician** SamPSON Gail 5.40 AM Linda 0-2008 /Medical 4a. Facility Name (If not institution, give street and number) Social Security Number 49-70 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) **Funeral** 1□M 2017 Months Director 10c. City, Town or Location 10a State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If tem 27 is marked than "inaturaly, or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at any injury or other traumatte event, the Medical Examiner must be notified at No 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. Never Married 2 Mamied 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, sampson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lane Mitchellville, Mb 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Deremation 3 Removal from State 4 Donation 5 Other (Specify) 10-17-08 RIVERDAILHARK Bianchi 814 Upshur ST NW Wash, DE 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant lor 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes ■ No page 2 s 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes No 2 1 Inpatient 2 ER/Outpatient 3 DOA Presidence 6 □Other (Specify) To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 6 completed cause of death (Item 23a) (Type, Print) S+ NW Wash, DC 20010 110 Irving

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🚄 🖰 🖯 🖰 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2008 35 PM Jennie Mae Scott tober /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 23,1924 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 212-26-4561 83 Dec. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Evanthas must be notified at 1⊠Yes 2 No Director Prince George's Lanham MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 U.S.A. 5603 Lundy Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 ⊠ No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black <u>Ş</u> 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jolly Preston Coker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Prentiss L. Scott/Son 5603 Lundy Dr., Lanham, MD 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition of J 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Department of Important: If any Injury or Ft. Lincoln Cemetery 10/24/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotc ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Severa physician and the burial-transi Anemi Due to (or as a consequence of): P.O. Box 68760, requires that the death certificate be Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) a I Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 Nation 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 28d. Describe how injury occurred F 28c. Injury at Work? 27. Manner of Death After t 1 Natural 5 Pending investigation Rehabilitation cater 00Tobe115, 2008 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number)

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State Registrar

DHMH 17 Rev 1/2001

OCT 2 8 2008

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 18, 2008 **Physician** 11:35P M FARMATTA SNETTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 7, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours LIBERTA 1 M 2 F 1924 84 Director <u>218-31-8138</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, If Modical Examinary pages. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □ Ves 2 □ No OLNEY Director MD MONTGOMERY 10f. Zip Code 20832 10g. Citizen of What Country? 10e. Street and Number 9 SHADOWRIDGE CT LIBERIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify: δ 3 TWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC DOMESTIC 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JEBE SAMBA WILLIAM H. JAMES ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAREY/DAUGHTER FRANCES SHADOWRIDGE CT., OLNEY MARYLAND 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PETERS CHURCH CEM 11/8/08 CALDWELL, LIBERIA 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility 21. Signature of Funeral Service Acenses CAPITOL MORTUARY 1425 MARYI AND AVE. N.E. WASH., D.C.-20002 complications that cause the death. only one cause on each ine. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o shock, or heart failure. Life Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans umonia (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performeto? Yes 2 No 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27 Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □No investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the 1 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) D0068026 68 Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Olven Tadmaja Dandi 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

OCT 2 4 2008

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Baltimore,	20 2		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Place of Dispo cemetery, crei verda	matory or	other plac	_{e)} 1 (-2008		ation - City or 7erdal						
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3	Physician /Medical Examiner popularistransis		disease or condition resulting in death)	Acute Cor	onary	Sy	ndgoi	me					TIIS	Lanc				
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4	0			npleted cause of death (Item														
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	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2008	32. Registrar's Signa	Э													

Hospital or Attending Physician: 24 hours after death. lin 2 BC

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 17, 2008

Registrar

30. Name and address of person who completed cause of death (Item 23a)

29%. Signature and title of certifie

Laron Locke MD. 31. Date filed (Month, Day, Ye 0CT 2 3 2008